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*What numbers do not reveal..., and incentive is not addressing...*

**A PRELIMINARY STUDY OF EFFECTIVENESS OF  
FINANCIAL INCENTIVES FOR RECRUITMENT AND  
RETENTION OF SKILLED HEALTH PROFESSIONALS FOR  
THE PUBLIC HEALTH SYSTEM IN ORISSA**

*Indira Chakravarthi*

2012



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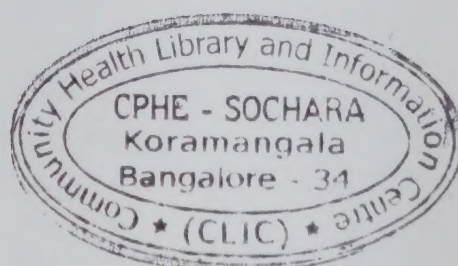
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**Copies: 50 (fifty only)**

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PH-100 p12  
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## **PREFACE**

Public Health Resource Network (PHRN) is pleased to bring out this Working Paper titled “*A Preliminary study of effectiveness of financial incentives for recruitment and retention of skilled health professionals for the public health system in Orissa*”. This working paper is part of the advocacy research commissioned by PHRN to initiate and enrich debate on public policy, governance and development, with a special focus on health and nutrition.

Lack of public debate is a major gap in public policy. PHRN hopes that these Working Papers will form a first step towards providing comprehensive and robust evidence base related to new economic reforms and strategies, and will lead to further discussions and analyses in the respective areas. The Working Papers are aimed at bringing together active practitioners, academics, policy makers and other stakeholders for a dialogue and engagement towards bringing about equitable public policies.

In recent years, with the emergence of a strong public health movement in India, there has been consistent and coherent pressure on Central and State governments to perform better on public health services. This has resulted in many state governments initiating new strategies or reforms to improve and strengthen health systems, which include reforms to improve human resources for health. However, many of these strategies or programmes are rolled out without learning from past experiences or any proper piloting. Further, post implementation, these strategies are not properly evaluated for their effectiveness, limitations, and challenges.

Scarcity of skilled medical professionals has been a perennial problem plaguing Indian public health scenario. Over the years, various strategies have been evolved to manage this problem and since health is state subject, different states have usually adopted different strategies. The objective of this Working Paper is to understand and discuss in detail the various measures adopted and practiced for recruiting and retaining of skilled medical personnel in rural and difficult of areas of India, especially that of financial incentives.

We thank Dr. Indira Chakravarthi for undertaking and meticulously completing this study on behalf of PHRN. We also thank our funders ‘ICICI Foundation for Inclusive Growth’. We also thank all friends and colleagues involved in creating this Working Paper for their tremendous contributions to this valuable work, and sincerely hope that they will continue to be involved in our future efforts.

**Dr Ganapathy Murugan**  
**Public Health Resource Network**  
**September 2012**







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## **ACKNOWLEDGEMENTS**

*I wish to thank Dr. Vandana Prasad, Dr. Madhurima Nundy, and Dr. Ganapathy Murugan of Public Health Resource Network, Delhi, for reposing confidence in me by requesting me to undertake this study on the effectiveness of monetary incentives in Orissa for recruitment and retention of doctors in the public health services in rural areas. Carrying out the field work and then writing out this report has turned out to be a challenging task, and I hope I have been able to do justice to it.*

*I am grateful to Madhurima and Ganapathy for also making all the necessary travel arrangements to Orissa for the field work, as well as being patient with me in spite of the delay from my side in shaping the report to my satisfaction.*

*The field work in Orissa would have been impossible without the support of Satya Patnaik, Subhashish Mohanty, and Madhumita Pati of PHRN Orissa. Satya accompanied me to both Mayurbhanj and Koraput-Kalahandi, while Subhashish was with us in Mayurbhanj and Madhumita in Koraput-Kalahandi. In both these places they made good travel arrangements and scheduled our visits well so that we could cover many facilities without much inconvenience, despite the difficult terrain. Mr Pal also provided guidance in Mayurbhanj district, while Madhumita undertook a pilot visit to Koraput-Kalahandi to make preparations for our field work there. Satya and Subhashish also organised the interviews with the state level officials at Bhubaneswar.*

*Along with the PHRN team at Delhi and Orissa, I thank all our respondent doctors and officials for agreeing to spare time for us and sharing their experiences and views. We were overwhelmed by the spontaneity and sincerity of the responses from many of the respondents, and I hope that I have been able to faithfully convey the information and issues shared by them, and that through this study we are able to effect some small changes in the difficult circumstances in which many of them are trying to work.*

*I thank all the reviewers for their useful suggestions and comments that have vastly improved it. Needless to say, the conceptualization and views expressed are mine, so are the inadequacies and mistakes.*

*Indira Chakravarthi  
September 2012*



## **ABSTRACT**

### **Background**

Lack of skilled personnel for healthcare facilities in rural areas, has been a chronic problem for several decades now. Since the 1990s various measures have been recommended and adopted for recruitment and retention of doctors and other skilled personnel. Providing financial incentives is reported to be the most common strategy. As yet there are no comprehensive evaluations from India of the effectiveness of these measures for recruitment and retention of health personnel in rural areas. This study attempts to fill this gap by undertaking an assessment of the financial incentives scheme in the state of Orissa.

### **Methods**

This study is based on desk research and qualitative methods of discussion with doctors and officials at the state & district level, using an open-ended check list to structure and guide the discussion. Districts, health facilities and doctors were purposively selected. Two districts from 11 incentive districts, Koraput and Kalahandi, and one from a non-incentive district, Mayurbhanj, were studied. This work was carried out in two phases, in December 2011 and February 2012 respectively. In all 27 facilities, comprising CHCs-PHCs-SDH and DH were covered. There were 35 respondents in all, covering 30 doctors in peripheral facilities, of which 11 were from the non-incentive district and 19 from the two incentive districts. Discussions were held on a range of issues, such as: the incentives scheme, on why they had joined the government health services, on why doctors were not willing to work in facilities in remote areas, on what should be done so that doctors would join-government health services.

### **Findings**

Our findings and the government's own figures indicate that incentives have not been very effective at improving availability of doctors in public health facilities, specifically in the peripheral institutions. While a section of medical graduates is joining the government health service, not all are staying.

It was not that monetary incentive was the main motivating factor for joining or staying in the public sector, but there were a variety of personal and other reasons, such as limited options in a limited private sector. Reservation of seats for post-graduation for in-service doctors has also been a reason, at least for fresh graduates. Vacancies in several non-incentive districts have been as many as or even more than that in the incentivized districts. The central issues for all the doctors were found to be unsatisfactory service and working conditions, poor infrastructure, and the overall backwardness of the region.



It came out clearly that if the conditions are not improved then such incentives would not work. The basis for selecting regions for which incentives will be given is not very clear; the financial incentive measure remains a 'temporary' one, subject to annual renewal on concurrence from the Finance Department. Some improvements due to NRHM seem to be at the cost of increasing administrative work on MOs, leaving little time for clinical work and study.

## **Discussion**

While the shortage of doctors may be particularly acute in parts of Orissa, it is widespread and afflicts all the states, to a greater or lesser extent. Further, the shortage is not limited to just rural facilities; public hospitals in urban areas too are facing similar problems.

To address this shortage isolated measures focusing only on incentivization, or multi-skilling, or some regulatory and educational measures, are being adopted. Available evidence indicates that these are of extremely limited effectiveness. There is need to pose and address the question: why are doctors not joining government health services? All doctors, both in incentive and non-incentive district, are of the opinion that if infrastructure is developed, service conditions, living and working facilities are improved, then doctors will join and stay. However, the chronically dysfunctional status of public sector institutions and the unsatisfactory working conditions, which are critical also for good quality care, continue to remain largely neglected. One needs to ask why it is so.

The larger questions are: What are the barriers to achieving satisfactory working conditions for doctors, to health systems strengthening? Why are recommendations of comprehensive strategies and systemic approaches ignored, and only piece-meal measures implemented? Can the shortage of personnel for public sector health facilities be addressed without confronting the influence and impact of the larger political ideologies and compulsions of neo-liberalization, and the drive by the states towards promoting private interests in every sector, including healthcare? The answers to these will influence the very understanding of Universal Health Care and strategies adopted for health systems strengthening.



## **BACKGROUND**

Lack of skilled personnel for healthcare facilities in rural areas, especially in those considered 'difficult' or 'remote' has been a chronic problem for several decades now. Although recommendations were made as early as in the 1970s for re-orientation of medical education and training of community based health workers, such schemes were never seriously implemented. Since the 1990s various measures have been adopted by several states for recruitment and retention of doctors and other skilled personnel for facilities in rural areas. These measures have been broadly categorized as follows (from PHFI & NHSRC 2011):

1. Educational measures aiming to preferentially admit only those students likely to serve in under-serviced areas and to mould education for recruitment and retention in rural service.
2. Regulatory measures insisting on rural service as pre-qualification to be considered for admission to post graduation courses; or bonds for doing rural service after the course.
3. Financial and non-financial incentives for working in facilities in rural and/or remote areas.
4. Workforce management policies, such as transfer policies that provide for rotational posting in difficult areas and give preference to those who would work in a remote area of their own choice.
5. Multi-skilling & alternative service providers.
6. Alternative service delivery models, such as public private partnerships

Of all these measures providing financial incentives is reported to be the most common strategy used by states to attract and retain the skilled health personnel in rural areas (PHFI & NHSRC 2011). In several states rural postings have been classified according to their degree of remoteness. In around 18 states (Andhra Pradesh, Andaman & Nicobar, Chhattisgarh, Haryana, Himachal Pradesh, J& K, Kerala, Lakshadweep, MP, Maharashtra, Manipur, Nagaland, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura and Uttarakhand) general and specialist doctors, serving in rural areas get "difficult area allowance" in addition to their regular salaries. Five of these states - Haryana, Maharashtra, Nagaland, Rajasthan and Tripura - also give similar incentives to ANMs, nurses and paramedics.

Available evidence of the effectiveness of financial incentives suggests mixed results (WHO 2010). In Australia, for example, financial incentives were set up for long-serving physicians in remote and rural areas and the amount paid varied according to location and length of service. One of these incentive plans succeeded



in achieving a 65% retention rate of physicians after five years. In the Niger, financial incentives were responsible for increasing the percentage of physicians, pharmacists and dentists working outside the capital city. But two years after implementation, the proportion of health workers choosing to go to these areas had not changed significantly (from 42% at the start to 46% after two years). A mid-term review of the Zambian Health Workers Retention Scheme found that within two years of implementation, the scheme had been able to attract and retain more than 50 doctors in rural areas, some to areas where there were previously no doctors available.

As yet there are no comprehensive evaluations in India of the effectiveness of these measures at drawing in and retaining health workers in remote and rural areas. An extensive review of the literature on evaluations of interventions to increase the availability of health workers in remote and rural areas found very few studies originating from developing countries in Africa, Latin America or south-eastern Asia (Dolea et al 2010). The majority of evaluations were conducted for educational programmes and, to a certain extent, regulatory interventions such as compulsory service or bonding schemes. Only four studies were found in both the financial incentives and support programmes categories, none of which were from India.

This study attempts to fill this gap by undertaking an assessment of the financial incentives scheme that has been adopted by the state Government of Orissa as one way to address shortage of doctors for rural areas.

## **SECTION I**

### **HEALTH INFRASTRUCTURE IN ORISSA – BRIEF PROFILE**

As per the State HMIS, of the 6688 SHCs, 212 were without ANMs, 2312 were without Health Worker (male), and 412 without either. Of the 1279 PHCs functioning, 712 were functioning without Nurse, 157 were without doctors, 881 PHCs had either allopathy or AYUSH doctor only (69%); while 98 PHCs were functioning with 4 doctors, 26 with 3 doctors (MOs), and 117 with two doctors (MOs). The services of Laboratory Technicians required for basic diagnostics were not available in 1162 of the 1279 PHCs (90 %).

Of the 6688 SHCs available, 2434 were functioning in rented buildings, 2277 without regular water supply, 3211 without electricity, 1082 without motorable approach road, and only 3534 SHCs had ANM quarters. Of the 1279 PHCs, 33 were in rented buildings, 312 were without regular water supply, 220 PHCs without electricity and 112 were without motorable approach road, 132 PHCs only were functioning with 4 to 6 beds. The state government had taken up construction of

382 SHC buildings and 40 PHC buildings. The construction of 2547 buildings including 1596 in tribal areas had to be taken up (NHSRC 2009).

Table 1: Status of peripheral health facilities in Orissa

	Sub centers		PHCs
Total no	6688	Total no	1279
Without ANM	212	<b>Without doctors</b>	<b>157</b>
Without HW (M)	2312	<b>Without nurse</b>	<b>712</b>
<b>Without both</b>	<b>412</b>	<b>Without Lab technicians</b>	<b>1162</b>
In rented buildings	2434	In rented buildings	33
Without ANM quarters	3154	With 4-6 beds	132
Without regular water Supply	2277	Without regular Water supply	312
Without regular electricity supply	3211	Without electricity Supply	220
Without motorable approach road	1082	Without motorable approach road	112

The state thus requires: improvement of the large numbers of existing infrastructure, as well as recruitment of a large number of additional doctors and specialists for existing facilities, and additional facilities required as per IPHS norms. The vacancies at every level were reported to be due to reasons such as delays in constituting Promotion Committees, pending court cases, non-reporting on postings to rural / tribal areas etc. (UNFPA & Xavier Institute 2007 cited in NHSRC 2009).

Since the mid-1990s a number of reforms have been initiated by the state government in the health sector in Orissa, namely the DfiD funded Orissa Health & Family Welfare Project, implemented in two districts and the World Bank funded Orissa Health Systems Development Project. These covered administrative and operational systems, personnel policies including skill development for better service delivery, and some aimed at giving a minimum health guarantee to the people.

The Orissa Health System Development Project was implemented between 1998-2006, with a loan from the World Bank of more than Rs 300 crores and around Rs 66 crore from the state government. This project included construction of hospital buildings, supply of medical equipment, mobile treatment facilities, and development of health system in tribal areas.



Prior to the setting up of the state Human Resource Management Unit (HRMU) in 2009, donor-supported reforms initiated in 1990s and subsequently the state health policy vision 2010 (Government of Orissa 2003) all had proposed various measures for health human resource development. The Government of Orissa in partnership with DFID in a strategic review of the Orissa health sector in 1996 observed that *“in-service training of personnel”*, one of the components of health project inputs of the previous ten years, *“did not bridge the skill-gaps of the service providers”*.

Subsequent reforms of the state government had health human resource development as a major constituent. The following reforms to strengthen, and improve capacity of health personnel were introduced.

- Changed Internship training programme for better community health orientation.
- Short-term training for general doctors in anesthesiology in CHCs.
- Multi-skilling of pharmacists as lab technicians for TB and malaria programmes.
- Mandatory pre PG service in remote districts helped fill vacancies, and provided a rural orientation.

Since 1999 this process was taken forward by the Orissa Health Sector Strategy Initiative.

Some of these reforms in human resources, introduced to bring in doctors for health facilities in rural and/or remote areas are described below:

i) Mandatory pre-PG rural service introduced in 1999. Under this scheme, 11 districts, to which doctors were generally unwilling to go to and which have consistently had a large number of vacancies, were selected, and health institutions in them identified. The entrance examination for the medical post graduate (PG) courses is held one year ahead of the date of admission. Those who qualified for admission were assigned to one of the institutions in the 11 districts. Those who were not already in government employment were given contract appointments and assigned to these districts. The doctors were to work in these institutions for a year, and only after obtaining a certificate regarding completion of the period, allowed admission into the PG course (<http://cbhi-hsprod.nic.in/listdetails.asp?roid=155>). The initiative was reported to be extremely successful, ensuring the presence of doctors in difficult and remote areas (Gupta 2002). This success has been attributed to the fact that the assignment is for a limited period only, and it is linked to the much sought after PG degree. However, precisely because it is short term posting, doctors may not work with full commitment.

ii) Internship training scheme was introduced in 2000, to improve the quality of community health training of medical graduates. Under this scheme, interns were to be sent to community health centres to be exposed to real community health situations and get ‘hands on’ training. They were to be supervised by both, the medical officers in charge as well as their medical college teachers. This scheme was



expected to expose young doctors to the rural health scenario; produce better trained doctors; expected to promote better attendance of doctors in rural health institutions if, and when, these doctors joined the state health service at a later date (<http://cbhi-hsprod.nic.in/listdetails.asp?roid=156>). This scheme had the disadvantage that the facilities were poorly equipped and the medical college teachers themselves did not have much exposure to the field reality,

iii) Financial Incentive To tackle absenteeism in the 11 tribal districts (Koraput, Malkangiri, Nawarangpur, Rayagada, Bolangir, Sonepur, Kalahandi, Nuapada, Boudh, Kandhamal and Gajapati), a resolution was passed in February 2006 to give additional financial incentive to doctors working in these areas to curb absenteeism. The resolution was passed only after the state finance department gave its clearance on January 17, 2006. It was to be piloted for a period of two years, with a review in December 2007 for extension (See Annexure I). The order provided for an incentive of Rs 2000 per month to Assistant Surgeons and specialists at district hospitals or dispensaries; and Rs 5000 a month for those working in peripheral hospitals or dispensaries. The incentive amount was increased in 2007 to Rs 4000 and Rs 8000 respectively.

A state HRMU was set up in mid-2009 to facilitate policy planning and research for human resource management in the health sector (Annexure II for notification on this). The measures proposed by, the HRMU to make the government service more attractive, to ensure retention, included the following (based on personal communication and from Government of India 2011):

- Entry level posts upgraded to Junior Class I
- Specialist allowance introduced @ Rs 3000 for all doctors posted against specialist posts
- More promotional avenues created. About 1000+ MOs had been promoted
- Number of seats in Medical Colleges, Nursing Colleges and para-medical institutions increased
- 5 years mandatory pre-PG service in peripheral institutions
- Post Mortem allowance of Rs 500 to be granted to each MO
- Legislation for protecting health service providers against violence in place, but implementation yet to be streamlined
- Age of retirement increased to 60
- Rational and transparent promotion policy being developed
- A data base of health personnel being created
- Adoption of a decentralized recruitment process
- Rogi Kalyan Samiti (RKS) empowered to recruit critical personnel, as and when need arose
- Creation of public health cadre in process

For the KBK regions the measures were:



- Additional financial incentives, Rs 8000 and Rs 4000 respectively. (This had been done already in 2007).
- Credit marks in PG study for doctors working in KBK districts
- Employment of contractual doctors, by CDMO, on a yearly basis, at Rs 25,000 for DH and Rs 25,000 for periphery. Preferably retired doctors.

Creation of cluster housing facilities at block level, for all the doctors of the block. The periphery doctors will stay in the clusters and travel to periphery hospitals to perform their duties. This was a way of ensuring that their families stayed in urban areas having access to all modern facilities. As yet there are no comprehensive evaluations from India of the effectiveness of these measures for recruitment and retention of health personnel in rural areas. This study attempts to fill this gap by undertaking an assessment of the financial incentives scheme in the state of Orissa.

## OBJECTIVES

The overall objective of this study was to understand the factors shaping the choice of the financial incentives scheme; the issues relating to the implementation and functioning of the scheme; experiences and views of those doctors who have joined and are working in these 'difficult' and incentive areas; to make a preliminary assessment of the effectiveness of the incentives at getting doctors for the public health system.

Specific objectives were:

- To examine the district-wise trends between 2000-2010 in the availability of doctors in PHCs and CHCs.
- To document the current status of all schemes for recruitment and retention of doctors in Orissa, both of the state government and under NRHM. This will include documenting the criteria for categorization of districts for monetary incentives.
- To examine the impact of the financial incentives scheme on recruitment and retention of doctors.
- Attempt to gauge impact on service provision.
- To attempt to draw out the factors that would favour / promote recruitment and retention of doctors in rural and remote areas.

## METHOD

### Data Collection

Information towards objectives (i) and (ii) was collected through study of relevant government documents and data.



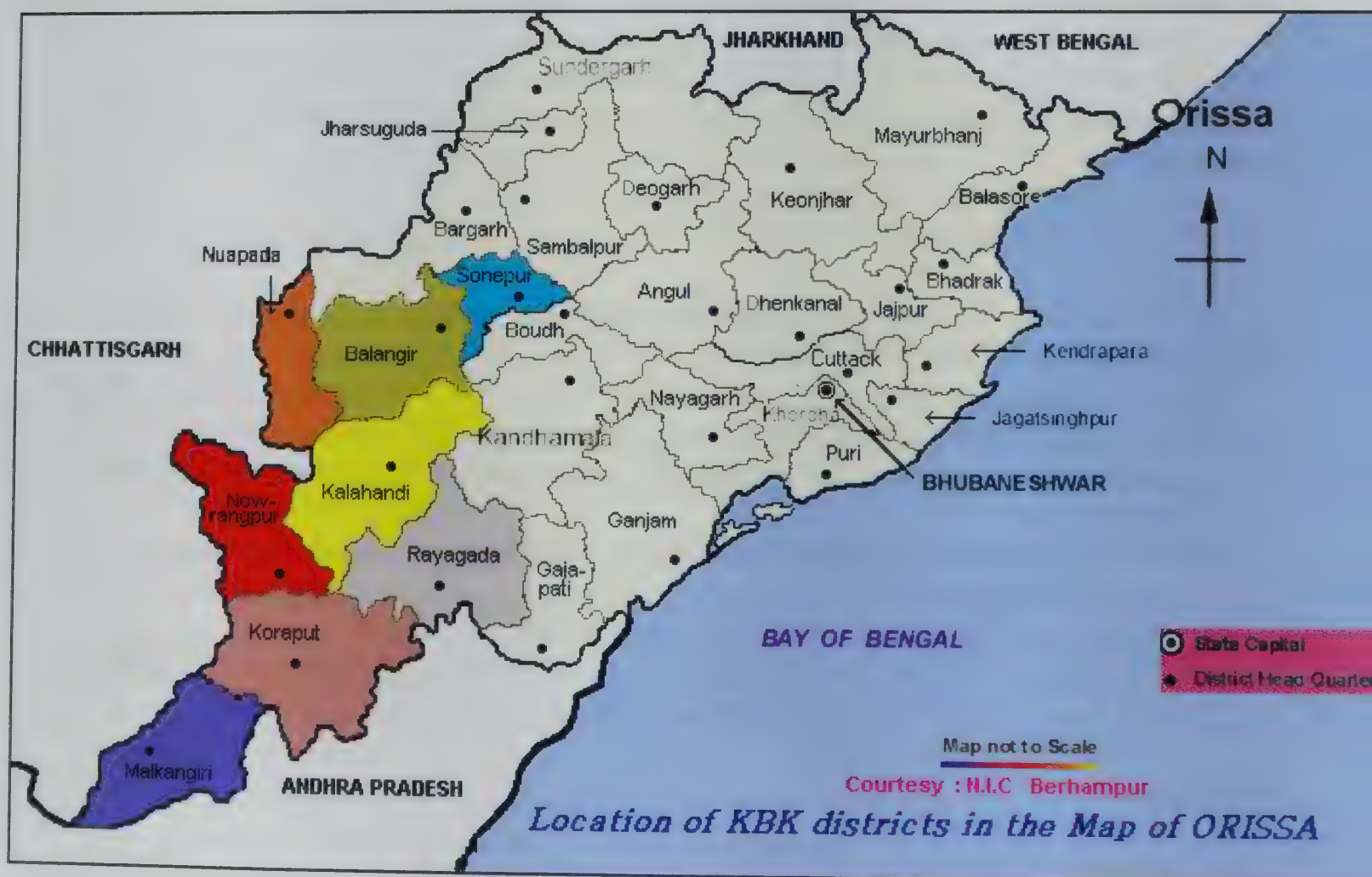
For objectives (iii), (iv) and (v) quantitative and qualitative information was collected for selected districts. Qualitative information was gathered by structured interviews and discussions with the following health system personnel:

- \*Functionaries and officials of the Health Department at the state & district level, including DPMs.
- \*Doctors from health facilities in the incentive and non-incentive districts.

### Sampling

Selection of districts and respondents: The districts, the health facilities and the doctors were purposively selected.

- \*Two districts from the 11 incentive districts, Koraput and Kalahandi, and one from the non-incentive district, Mayurbhanj, were studied.



- \*The selection of the respondent doctors was guided by several preferred criteria. Namely: (a) Location of the facility (CHC and PHC) whether easily accessible (situated on or close to main roads) or in remote parts (difficult to reach-no proper roads). Preference was to be given to meet doctors in PHCs in the difficult areas. (b) Number of years of service of the doctor. Those who joined



before the scheme was started as well as those who joined after. (c) Female doctors

Structured, open-ended interviews and discussions were conducted with doctors in selected facilities in three districts: Mayurbhanj (non-incentive district); Koraput and Kalahandi (incentive districts). This work was carried out in two phases, in December 2011 and February 2012 respectively.

Number of health facilities visited in the districts<sup>1</sup>

The total number of CHCs and PHCs in the three districts were as shown in the Table 2 below:

Table 2: Number of peripheral facilities and of doctors in sample districts

District	Blocks	CHCs	PHCs	No of doctors		
				S	P	V
Mayurbhanj	26	27	78	272	269	3
Koraput	14	16	47	169	118	51
Kalahandi	13	16	45	176	134	42

In all 27 facilities, comprising CHCs-PHCs-SDH and DH were covered. The break-up is as follows:

CHCs	20*
PHCs	5
SDH	1
DH	1

\* Of these 5 were Block PHCs that had been *re-named as CHCs* by a state government notification of October 2010, whereby 116 Block PHCs and 35 Area Hospitals were renamed without creation of additional posts, with a view to rationalizing the health institutions. According to this notification ‘doctors and specialists would be posted in the CHCs so re-named subject to availability of doctors’ (See Annexure III for the NOTIFICATION). So these facilities are CHCs only on paper; they continue to have one or two doctors as in PHCs and no specialists.

Secondly, once in the field we were told that in some blocks the MO IC posted in some PHCs (especially those that also had AYUSH MOs) were actually deputed to work in the CHC due to shortage of MBBS doctors, and would be therefore available in the CHC. These MOs went periodically to the PHC. In few cases the PHC had no accommodation whatsoever and the MO IC could not stay there; they stayed in/with

<sup>1</sup> To maintain confidentiality the specific health facilities are not being identified here.



the MO of the CHC and travelled to the PHC on specific days, such as for VHNDs and immunization.

Total number of respondents

The total number of respondents thus was 35, covering 30 doctors in peripheral facilities, of which 11 were from the non-incentive district and 19 from the two incentive districts). This included two AYUSH MOs under NRHM, and 5 officials at district and state level. Among the officials at the state Directorate of Health Services we met with members of the state Human Resource Management Unit,. We also had a group discussion in the capital city of Bhubaneswar with three professors of community health from one of the three Medical Colleges in Orissa, on the incentives scheme and reasons for shortage of doctors in the state government health services.

Total number of facilities and respondents covered in the study are as shown in below:

District	facilities	doctors
Mayurbhanj	9	11
Koraput	10	11
Kalahandi	6	8
TOTAL	25	30

Interviews / Discussion with Medical Officers in Charge

The interviews and structured discussions with the doctors were conducted in the respective health institutions in the three districts by a three-member team, after explaining to the doctors the purpose of the study and how the responses would be used.

Ethical issues: It was explained to the doctors that the findings of the study would be published, but confidentiality would be maintained and individual names would not be mentioned in the publication. A confidentiality letter was given to each respondent.

We had detailed discussions with them on a range of issues relating to their work; such as: the incentives scheme, on why they had joined the government health services, on why doctors were not willing to work in facilities in remote areas, on what should be done so that doctors joined the government health services, on the problems faced by the doctors and other health workers, on the NRHM.



Every doctor we approached shared willingly, and in several cases rather enthusiastically, facts, individual experiences, problems, and perceptions regarding the government health services, reasons for why doctors were joining or not joining government service, whether or not monetary incentive was an effective remedy, and what would be an effective solution to get doctors to join.

In fact some doctors remarked that during their many years of service this was the first time that they were being approached, in the health facility, by someone and were being asked about their views, experiences and problems.

## **CONSTRAINTS-LIMITATIONS**

Due to constraints of resources and time, we could not gather all the information, especially secondary information from the state level officials regarding the availability of doctors over the past ten years. In the field we could not also have discussions with members of the Rogi Kalyan Samiti, and with ANMs-ASHAs-VHSCs under the selected PHCs. Notwithstanding these limitations, we present rich qualitative information that has emerged from the discussions with the doctors, which touched upon issues beyond that of monetary incentives that affected availability of doctors for government health services. These in turn provide several insights regarding the factors internal and external to the health system because of which doctors are either reluctant or unwilling to work in certain areas.

The report also uses quotes, from other sources, much more than is normally done. This is so as the author feels that it is important to convey that the observations and conclusions of the author are also made by other doctors in the field, and not exclusively the author's own judgment.

## **SECTION II: RESPONSES & FINDINGS**

Before proceeding to the discussion on the responses and findings we give a brief background of the selected districts.

### **MAYURBHANJ**

Mayurbhanj, the largest district by area in Orissa, is one of the tribal dominated districts of Orissa and is a fully Scheduled Area district in the northern part of the state. Tribals constitute 57 per cent of the district population, although only 6 per cent of the total state population belongs to this district ([mayurbhanj.nic.in](http://mayurbhanj.nic.in)). Large parts of the district are covered by forests and the Simlipal Reserve Forest. The local people are largely dependent on agriculture and unemployment is considered to be high, although not exactly estimated. Due to lack of local employment opportunities migration is also reported to be considerable. About 80 per cent of



the population is reported to be living below poverty line; 90 per cent living in rural areas. The literacy rate is reported to be 24.10 % among STs and 37.8% among SCs. Parts of the district are reported to be inaccessible and lacking in basic infrastructure and facilities for education and health. This district receives assistance under the various programmes meant for tribal area development.

### **KBK Districts**

The erstwhile undivided southern districts of Koraput, Bolangir and Kalahandi (popularly known as KBK districts) were divided into eight districts in 1992-93: Koraput, Malkangiri, Nawrangpur, Rayagada, Bolangir, Sonepur, Kalahandi and Nuapada. These districts are part of the Eastern Ghats, and are largely hilly and forested areas. The KBK districts account for 19.80% population of the state spread over 30.60% of the geographical area. Tribal communities comprise 38.41% of the population in this region. This includes four primitive tribal groups (PTG), i.e., Bondas, Dadai, Langia Sauras and Dangaria Kandhas. 16.25% population belongs to the Scheduled Castes (SC) communities as per 2001 Census. 44 CD blocks are included in Tribal Sub Plan (TSP). 89.95% people of this region still live in villages, and it has a lower population density (153 persons / sq.km) in comparison to 236 for Orissa.

This region is one of the poorest regions in the country. As per an estimate (based on 1999-2000 NSS data), 87.14% people in Southern Orissa are below poverty line (BPL). Rainfall is generally erratic and unevenly distributed. Irrigation facilities (both surface and lift) are inadequate. More than 50% of forests of these districts are degraded. Employment opportunities in the region are limited. Agriculture, which is the major economic activity, does not generate adequate avenues of employment for the rural poor, leading to significant migration from the region. The literacy rate at 43.33% is much lower than the State average of 63.08%. The female literacy rate is 29.10% (State average of 50.50%). The population is reported to suffer from high morbidity on account of under-nutrition, as well as endemic malaria and other localized diseases.

While planning and development of an area and allocation of funds are primarily the responsibility of the State Governments, the Central Government has also been allocating money to this region through Special Area Programmes, specifically to reduce regional imbalances. On paper at least, the Kalahandi, Bolangir and Koraput (KBK) districts of Orissa have been the focus of attention from the central government since the 1980s, when starvation deaths of tribal people were reported from here. Several special measures and grants have been allocated for the area:

- i) In the year 1988, a special programme, Area Development Approach for Poverty Termination (ADAPT), was formulated and implemented in 15 blocks, 8 in Kalahandi and 7 Koraput district, to provide employment round the year to the rural poor and to change agricultural strategies.



- ii) A Long Term Action Plan (LTAP) was prepared, to be implemented over a seven year period, from 1995-96 to 2001-02, for drought and distress proofing, and poverty alleviation and development, at an outlay of Rs. 4557.03 crores. However, LTAP did not take off for want of availability of sufficient funds.
- iii) A Revised Long Term Action Plan (RLTAP) (1998-2007) was submitted to Government of India in 1998, for speeding up the socio-economic development by synergizing effectively various developmental activities and schemes implemented by both Centre and State.
- iv) There has been funding under the Special Plan for the KBK districts from the year 2002-03, focused on tackling the main problems of drought proofing, livelihood support, connectivity, health, education, etc. An allocation of Rs.250 crore per annum was being made for the Special Plan for the KBK districts of Orissa during the Tenth Plan period, which continued during the Eleventh Plan.
- v) The Union Government initiated the Backward Regions Grant Fund (BRGF) in 2006-07 to specifically address the issue of reduction in regional imbalance in the country to replace the Rashtriya Sam Vikas Yojana (RSVY).
- vi) The KBK districts, along with several other districts of Orissa, receive central assistance also under the Integrated Action Plan (IAP), formulated in November 2010 by the Planning Commission as a special scheme to address the development of tribal and backward districts in Left Wing Extremism (LWE) affected areas (identified by the Ministry of Home Affairs for coverage under its Security Related Expenditure (SRE) Scheme). Under this IAP, a block grant of Rs.25 crore and Rs.30 crore per district during 2010-11 and 2011-12 respectively was placed at the disposal of a district level Committee, to be spent for development schemes according to need, for public infrastructure and services such as School Buildings, Anganwadi Centres, Primary Health Centres, Drinking Water Supply, Village Roads, Electric Lights in public places such as PHCs and Schools etc. Currently, the implementation of IAP in the districts is reported to be in full swing (<http://pib.nic.in/newsite/erelease.aspx?relid=79472>)<sup>2</sup>.

The beauty and serenity of the gentle hills and valleys of KBK should not blind one to yet another harsh reality of this region. It is home to one of the largest and richest bauxite deposits in the world. In the name of exploiting these resources for the development of the region, three large alumina refineries have been located here, one each in Koraput, Kalahandi, and Rayagada. One of these by the public sector NALCO was set up in the 1980s in Damanjodi, Koraput.

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<sup>2</sup> According to a newspaper report, about Rs 1.54 crore from this scheme was being spent on setting up a blood components separation unit at the Koraput District Hospital. The required apparatus was to be purchased soon and the unit was expected to be functional within the next few months. Once functional the unit would cater to the regions of Koraput, Kalahandi, and Rayagada. (The Times of India, 16.03.12, [http://articles.timesofindia.indiatimes.com/2012-03-16/bhubaneswar/31200623\\_1\\_blood-component-separation-unit-blood-cells-koraput](http://articles.timesofindia.indiatimes.com/2012-03-16/bhubaneswar/31200623_1_blood-component-separation-unit-blood-cells-koraput)).



By all accounts these development projects have not lifted the region out of their so-called ‘backwardness’, and have not benefitted the local tribal people in terms of employment and infrastructure, as it was claimed it would. As this study shows, large parts of this region remain deprived of basic health and education infrastructure too<sup>3</sup>.

In view of these allocations, the question looms large: Why is it that in spite of spending thousands of crores of rupees for almost two decades, in the name of development of the KBK region, it continues to lack many of the basic infrastructure in terms of employment, irrigation, communication, educational facilities, etc, and continues to remain the poorest region in the country? Where has all the money spent in the name of development of this region gone?

Brief Profile of doctor - respondents

All the doctors we met belonged to one of the following districts: Balasore, Bargarh, Berhampur, Bhadrak, Cuttack, Dhenkanal, Ganjam, Jagatsinghpur, Mayurbhanj, Rourkela, or Sonpur (largely the coastal districts or from the northern parts of Orissa). We came across only one doctor each who hailed from Koraput and Kalahandi, who were in the posted in the same district. There were two female doctors, one of them an AYUSH MO. There were 8 post-graduates, either paediatricians or gynaecologists, and one each in chest diseases, and community medicine.

The following Table gives number of years of service of the respondents.

Table 3: number of years of service of respondents

No of years of service	Mayurbhanj	Koraput	Kalahandi
Up to 5	2	5	3
6-10	1	3	1
11-15	nil	1*	2+1*
16-20	2	nil	Nil
21-25	1	1	Nil
>25	4	nil	Nil

(The number of doctors does not add up to 30 as we do not have information for all)

<sup>3</sup> Not only has there been no development here (in the commonly understood sense of the term). On the contrary, this region is currently a site of intense struggle by the tribal people, who are resisting bauxite mining on the hills here for the alumina refineries, as it will lead to more deforestation, deprive them of their sources of livelihood, and only further impoverish them. There has been mass resistance for more than a decade now. The region has now been declared as LWE affected and there is heavy presence of central para-military forces in several blocks in Koraput and Kalahandi districts of KBK.

\* MOs whom we could not meet, but spoke to the other doctors in that institution. The one in Koraput has been there for 11 years, the one in Kalahandi for 15 years and he belonged to the same district.

15 of our respondents had been in government service for less than 10 years; a larger proportion of such doctors (12) were in Koraput-Kalahandi. Of the 6 who had been working for more than 20 years, 4 had worked for more than 25 years, and were located in facilities in Mayurbhanj. All four belonged to that district too.

**The following section gives in detail the responses to some of the specific probes that were used for the discussion.**

1. Reasons for joining the state government health service - why did you not opt for a private/corporate hospital?

In all the three districts, non-incentive and incentive, the responses to this fell in three broad categories and broadly corresponded to year of completion of graduation and years of service (used as a proxy for age):

The older doctors (those with more than 15 years of service) said:

“Government service was the only option available in our times”.

“There was no private sector then” (1970s-80s).

“Personal reasons”

According to a doctor with 25 years of service, “When I passed out in early 1980s not many options were available to medical graduates. I had to stay here to take care of my family and got this job with great difficulty. Many from my batch are in the government service. Nowadays doctors have the option of working either in private hospitals or in company hospitals, such as those of Jindal”.

According to one pediatric specialist posted in non-KBK district, “In our times we did not have much awareness. Presently specialists were not joining; they are more aware and conscious of the problems. The fresh entrants are aware of how the system works, of the work load; they feel ‘why get into all this?’ and opt for the private sector”.

The responses of the younger doctors (those with less than 15 years of service) were:

“Pre-PG posting”.

“In order to get advantage in PG admission”.

“I was interested in working for the poor people and also because of the advantage for PG”. “There was no incentive then (2004). I joined for reasons of job security. It



is not out of greed for the money; we can get better salary in private medical college: we hear that they pay Rs 50,000 to a lakh”.

“Joined because I did not want to work for the benefit of a single man; the government structure is a large structure; we get an opportunity to serve in different places”.

Interestingly, some of the younger doctors with less than 10 years of service had this to say about the private sector

“There are not enough private hospitals to absorb all the students who pass out every year”.

“There are no positions at our level, at the entry level; the demand is for doctors at senior level”. At the most about 50 doctors could get employment in the private sector (in a year).

“Does not pay much at the entry level – it is of the order of Rs 25-35,000. One will have to work in 2-3 private hospitals to earn this amount as in government, so will have to work all the time; some of my friends are doing it”.

“Private hospitals are located only in Bhubaneswar-Cuttack”.

“Private hospitals outside the state are better”.

## 2. Response to discussion on monetary incentives, its pros and cons

The questions posed were: What is your view about monetary incentives – is it effective? If yes – why? If no- why not? Have you worked before in an incentive district? If yes, then what was your experience there? Why did you leave that area and come here? (for those in non-incentive district) Would you have come here if there had been no incentive? Has it been effective – in what ways? Can it be made effective? If yes - how to make it effective? Do you think other factors need to be addressed in order to get doctors to these districts?

### *Responses from respondents in incentive districts*

According to one of the doctors – “We are getting a salary of Rs 30,000.....given an additional Rs 8000 to stay in a desert. Will you stay? Even if incentive is increased doctors will not stay if facilities are not improved”.

“We are not working for incentives”, “Have not seen doctors join because of incentives, as specialists one can earn much more”.

“No-one is willing to come here in spite of incentives. If infrastructure is improved and are comparable to those in company hospitals, and living conditions are improved then doctors will come”. (This doctor had been posted for many years in a public sector company hospital in the same district before being posted in the CHC).

“Incentives have a limited impact. Largely only young doctors come to the periphery, it is not only for incentives; it is as part of career compulsions. Because of pre-PG compulsion they join and then leave for PG”.

“Incentive is not the solution; only way to get doctors is improve the facilities; fill up all sanctioned posts, improve salary ...”

“Retention was not satisfactory; doctors who were posted here came and went away after spending 6 months to a year. There are no specialists”.

“Infrastructure and other conditions are bad; seeing this entire scenario people leave. It is not just because of opportunities in other places to earn. There are problems here such as lack of schooling for children. So people would like to go a better place even if salary is lesser”.

One young MO who had graduated in 2008, joined the government in 2010 and had been made MO IC just a few months ago (2011), had this to say, “Incentives play no role. Why increase incentive amount? Improve infrastructure, improve facilities, increase salary, have a clear transfer policy. Not all who join do so for PG seat. Those who wish to stay should have good working conditions”. He went on share some of the thorny issues.

*He was a second MO and had recently been appointed MO IC as no one wanted to take charge in that CHC due to its notoriety for political interference and harassment. As a fresh doctor they had clinical training but no training in administration. There was no systematic orientation and training after joining; there was an induction training, but attending that was dependent upon their being granted leave from headquarters by their seniors. Their seniors were not aware of the field situation; they wanted the efficiency of Senior Class I MOs from them with absolutely no training. Further, the number of programmes was increasing and they were being expected to deliver with the same limited staff. As In-Charge he was responsible for the welfare of his field staff; they were already burdened and one could not pressurize them further. There was too much stress due to administrative work and at times they had to make difficult decisions; there was no time to relax, to study for PG entrance. There was no option but to have more doctors.*

Another doctor, a pediatric specialist given charge as MO IC as the post was vacant, and who has been in service for more than 10 years, felt that the government may be giving incentives, but ‘in reality the government is actually stealing from us’; it was taking much more from us than what was being given to us. As the required number of doctors is not available, the few doctors who were present were made to do a lot of work and manage the health facility. They were also deprived of certain benefits.

“Staying in some of the PHCs was very difficult; some are not even located within the village but at a distance; there is also problem of language – tribal people did not speak oriya”.

“Don’t give incentives, but employ one person only for all the NRHM work”. “There is shortage of staff. Retired staff is not being replaced by DHS”.



According to a doctor with more than 25 years of service and placed high up in the district health system, "Doctors are not coming because there are no facilities – no accommodation, no water, no electricity. Take the case of some project such as a dam construction. The entire infrastructure is first constructed, and then the engineers and other staff move in. It is not so in case of hospitals and health centres – the doctor is simply sent to the rural area where there is nothing and is expected to provide services. The panchayat sometime donates land; a small room is built and the doctor is then expected to work. Why is this so?"

A group of doctors listed out several problems that deterred doctors from joining government health services:

- Poor pay structure – salary was not as good as in other states, such as in Andhra Pradesh.
- There was no incentive for PG doctors
- Same criteria were applied for fresh and in-service doctors for admission to PG; there was no relaxation in qualification for in-service doctors.
- PG- Diploma of DNB was not recognized in state
- Placing right doctors in right place, if an anesthetist or PG in chest and TB gets posted in PHC (N) it will be wastage of manpower as far as their skill is concerned, and de-motivating.
- There was no separate pay structure; no NPA for doctors
- There was a difference in salary between medical college doctors and in-service doctors
- There was no infrastructure to work; although there were some improvements after NRHM.
- There was no transparency in posting and in promotion (for instance: one CDMO started working in 1979 in a CHC; worked as an Asst Surgeon for 25 years in CHC till he got his first promotion in 2004 as CHC-in-charge; then to the District Hospital). Those who are in Cuttack stay there throughout their service.
- There should be promotion with special pay band.
- It takes a long time to get all the qualifications and become a doctor; a single MBBS doctor is superior to many other posts; this is not accounted for in pay structure. Even a lecturer is paid more than a doctor.
- Great disparity between us and other professionals; no acknowledgement of the greater tasks and responsibilities; lower status than OAS, judiciary where the people are less qualified than us. There should be a separate pay structure for doctors.
- There has been stagnation of health services due to bureaucracy. Affected people are not consulted; schemes made by clerks, bureaucracy.
- Incentives are not added to salary; have to pay bribes at different levels to get incentives and other official benefits. Corruption in the DHS. Getting work done at the DHS is very difficult. There is no system in place.

- There were problems due to reservations.
- There should be proper infrastructure for every institution.
- Between 1995 and 2000 we did not get salary regularly due to shortage of funds. Even now ANMs are not getting their salary regularly; state government is not giving matching grants.
- A specialist in DH is on call for 24 hrs; a MO in periphery is a single doctor serving 24 hours. Not many holidays; cannot leave headquarter even on official holidays. No concept of 'surrender leave'.

According to a young doctor who had completed his graduation in 2009 and was in the particular PHC since the past one year, **non-monetary incentives were more important than financial incentives**. He had been posted at a PHC that had no quarters and did not even have a building, or proper road to reach it. He and the female health worker had been deputed to work at the concerned CHC and the pharmacist had been deputed to work at another PHC, so how could he provide any services at the PHC? Even the CHC was poorly equipped – buildings for indoor, labour room and OT were just being constructed; there were no electricity and toilet facilities for the labour room. Only malaria and tuberculosis could be treated here; there were no specialists, and no laboratory or OT facilities. Even private facilities were not available in the town to refer patients to. They could not treat any emergency cases. As a young doctor he needed to learn from other doctors, but it was not possible in such a scenario. There was need for more doctors and for improvements in infrastructure and living conditions.

Most of the young doctors who had joined to avail of the reservation of seats for in-service doctors for PG admission said that there was so much work that there was little time to study, little time to read and update one's knowledge. Another doctor pointed out that although doctors joined for the PG reservation, it was difficult for in-service doctors to qualify: even if one got adequate time, the environment was not conducive to studying as one was isolated from one's colleagues in urban areas who did group study. He told us that in the previous year only 22 doctors qualified for the 60 seats reserved for in-service candidates.

Another young doctor also pointed out that 'doctors did not want to come to KBK districts as we do not learn much here; in other districts operations were performed at the CHC level. One does not learn much here'.

A few doctors pointed out that because of incentives absenteeism had reduced to some extent; that MOs did not take much leave and made efforts to stay at headquarter even if they had to live in rented accommodation.



One doctor was rather cynical about the state of affairs. According to him the issue of shortage and of doctors not wanting to join was a creation, a portrayal by the government to demoralize and de-motivate the doctors. The government is aware of all the problems of the health services; and also is aware that if these problems are solved doctors will join and stay. However, it was not interested in doing so - it was not interested in getting doctors for the government facilities. This was a ploy to allow the private sector to spread. "If conditions do not improve we will be compelled to go to the private and corporate sector even if we are paid less money".

#### *Responses from doctors in non-incentive district*

##### **A. Effectiveness of financial incentive in recruitment and retention of doctors in government services**

On whether financial incentive was an effective measure for recruitment and retention of doctors in the government services, some doctors from the non-incentive districts felt that they were not very effective; due to lack of facilities doctors were not going to KBK even with incentives. It was more important to develop infrastructure – proper housing was a must, facilities for education of children, provide sufficient doctors, nurses, and other facilities to be able to provide services.

One doctor said that 'Doctors from poor families join under schemes and incentives due to compulsions; but leave after some time... Skilled doctors are not able to function effectively due to lack of facilities; what is the point of learning more when we cannot use the skills here'.

'Doctors coming due to pre-PG compulsion are useful; however they are not provided with facilities and accommodation. If good facilities are provided they will work'.

'Incentives will not help. Pre- PG compulsion will help. There can be some reservation for in-service doctors. Need overall improvements in infrastructure'.

**'Incentives do not work. Doctors will work even without incentives, provided infrastructure and facilities are available'.**

##### **B. Need for infrastructure and improved service conditions**

According to one doctor there was no shortage of doctors in the state; doctors were not joining the government health service due to two major reasons: (i) there was a vast difference in salary in the state and central government. If service conditions were improved, if there was time-bound promotion, if DACP was introduced, then there could be some relief. (ii) Atmosphere was not conducive to work; the doctor had to do a lot of administrative/programme work. If there could be some division

of the programmatic and clinical components, there could be some relief. Given the shortage of doctors, why divert MBBS and post-graduate specialists towards administration of more programmes?

(iii) Need for good educational facilities for children in the peripheral areas. Or else government should consider re-imbursing our expenses on education for our children in urban areas.

Another doctor pointed out similar reasons for why doctors did not stay. Namely:

- Lack of infrastructure.
- Poor salary package – only now some improvements and specialist allowances were being given.
- Not much difference in salary from time of entry till after more than 10 years of service, even after 20 years earning Rs 34,000.
- No time bound promotion; superseded due to reservations.
- No transparent transfer policy.
- Doctors should get DACP (Dynamic Assured Career Progression) and NPA (Non Practising Allowance) – other PSC (Public Service Commission) officials earn more than us.
- No clear guidelines for the health system

Yet another doctor, a pediatric specialist at a sub-divisional hospital felt that 'incentives will not help – one has limited stamina; it is very difficult to work. There is political interference, harassment. Need to improve the system drastically, have more manpower – especially doctors and paramedical; separate administrative and technical'.

"Transfer policy faulty – have clusters around which doctors could be transferred. Say one cluster of Mayurbhanj-Balasore-Keonjhar. Should have DACP'.

### C. Poor quality of health facilities

One doctor, who has been working for more than 20 years, felt that there were areas in the non-incentive districts too where the scenario was similar to that in the KBK districts, and incentives should be given to work in those areas too. "Lack of communication, lack of housing and other infrastructure, were the reasons why doctors were not coming. There are inaccessible, hard to reach areas even in the non-KBK districts such as Mayurbhanj – no infrastructure, no motorable roads, in some blocks, such as in Simlipal-Jashipur. Two PHCs in that block are in the middle of the forest, 27 kms away from the block CHC and isolated from even the tribal habitations. It is difficult for the doctor to live there; there is no proper accommodation, no communication, absolutely no facilities available. The doctor and other staff live in the block town and travel to the PHC. The same cadre is expected to work in the block HQ and in the remote areas. There should be some distinction between these sets of areas, even within the district. Extra allowance should be given to work in such areas".



A similar view was expressed by a young MO-IC, who had passed out in 2006, and had worked on contract in NRHM, on ad-hoc basis in a PHC, and was now in regular service in a PHC since 2011. This doctor had joined the government health service as he wanted to get the advantage for PG admission. He shared his woes with us – there was an acute problem of staff in the hospital; the PHC he was in needed 2 doctors and 2 nurses, but he was the only MBBS doctor. It was an old facility and people came there as they could not go to the district hospital, but as a single doctor he could not provide even basic aid in an emergency situation; had to refer them to the CHC. There was no ambulance. Major problems, such as lack of electricity, lack of housing should be solved. It was a block HQ; yet electricity was a problem. The PHC premises were at a lower level than the road; and got completely flooded in the rainy season. **There had been no repairs and maintenance of the PHC premises over the past forty years. How could they stay and work in such circumstances?** While this was the situation of the PHC, living conditions for the doctors were just as abysmal. The house he was expected to live in was dilapidated and overgrown with weeds, and had no bathroom and toilet facilities. After repeated complaints only one quarter was being repaired. The other staff quarters were not being repaired.

In his view areas in the non-incentive districts were similar to KBK region – there was ‘no development, no communication’. Hence, same incentives should be given to doctors to work in this region. When asked about the availability of doctors in the better-developed districts, he said that “while coastal districts were more developed than this (Mayurbhanj), yet availability of doctors there too was not good - there were vacancies in PHCs in those districts too. Due to the government policy of posting doctors in KBK districts, the other districts were being deprived of doctors”.

According to him there was need to improve the facilities and infrastructure, revise the salaries, and to have time bound promotions. “Once posted, doctors were compelled to stay in the same PHC for as long as 20 years; they are not relieved at all”.

Another young doctor had similar comments. He said there were no facilities whatsoever in the CHC (no laboratory, no technician, nurses). He was only making clinical diagnosis, could not confirm anything as the diagnostic facilities were not there. He felt that one can work if all facilities were provided. There was too much administrative work for a beginner, and lesser clinical work.

### 3. Reasons why some doctors have stayed

There was a variation in the attitude of the respondents – from spirited and enthusiastic ones to pragmatic ones, to few spiritless, uninterested ones simply waiting to retire, or leave on a transfer or for the PG admission to come through. In the non-incentive district we came across few doctors who have stayed for more than 20 years. The major reason why they had stayed was due to lack of other options and



family responsibilities, as well as the fact that they belonged to that district and wanted to stay there due to personal reasons. Among these there was one motivated doctor who had persevered, and worked against all odds to improve the facility, and make it functional. Such doctors had gained respect from the local people and returned after briefly being away on transfer, reportedly due to popular demand.

In the incentive district some young doctors (those who had completed graduation after 2005) who had joined largely for getting advantage in PG admissions, expressed some sparks of motivation and desire to stay and continue working, subject to better conditions. Some said that in the hilly terrain they walked long distances up to 10 kms through forests to reach hamlet points to treat the villagers, as these villages were inaccessible by even motor vehicle. Another doctor in the incentive district, who had not got a transfer after the five years of posting in KBK, said that he did not mind staying, 'the people here are very innocent; I get respect from them, patient load is less, there is mental peace, not much interference'. Yet another doctor said that there was an impression that those of us who stay here and work may be 'making money' from the funds that are coming in; however, whether or not there was incentive and monetary benefits, they 'worked sincerely and honestly. This should be recognized, acknowledged, and compensated in some way'.

Thus, all the respondents, without exception, were absolutely emphatic about the impact of monetary incentives – that financial incentive by itself could not draw in doctors to work in the government health services. Majority of the doctors we met had joined before the incentive was introduced; and the ones that had joined after that said that the financial incentive was not the reason why doctors joined the government health services.

#### 4. Shortage of doctors and other staff

We were told that "Doctors were shown to be posted in difficult district, but were working here (in capital city)". In other words doctors are 'shown to be posted, but may not actually be working at the peripheral facility; those who are able to use influence do not stay there, or may get deputed to work in some other facility. One doctor in a CHC told us that in his facility two doctors had joined in his facility and then they left; there was no communication yet about their status. According to one professor, "The government has made a decision that all PG students of government colleges will have to serve at least one year in KBK area prior to joining the course. But it has been reliably learnt the high and mighty can give a go by to this requirement".

Doctors at one district hospital told us that there was no HR Cell for the District Hospital. Even the DH had shortages – there was shortage at all levels – of staff nurses, no radiologist. There are only few doctors, who too are caught up in administrative work, and were not able to attend to patients.



Regarding pre-PG compulsions, one doctor said that after completing PG the doctor would like to be in the SDH or DH, and not go to the periphery. “We get only gynaecology or paediatric specialties in the CHC”. In fact even District Hospitals were reported to not have anaesthetists; that retired doctors were being hired on contract. Officials kept making frequent adjustments by transfers and deputing doctors from one to another facility (or lower to higher), and there was no stability. In case of one CHC the surgeon posted there had been deputed to the SDH, and the CHC had to make a request for him when needed.

According to one doctor, doctors who were posted here came and went away after spending 6 months to a year. Retention was not satisfactory. There were no specialists. There is shortage of staff. Retired staff not being replaced by DHS.

**One doctor at a sub-divisional hospital was very emphatic that the ONE-MAN SHOW SHOULD STOP, referring to the situation where on paper his facility had 10 doctors but only 3-4 were actually working. This corroborated what was said about ‘shown posting’ and doctors actually available.**

A look at the figures of doctors in position over the years validates the observations of the doctors regarding shortages in the district as well as across the state

Table 4 below gives the trends in doctors in position and vacancies in Kalahandi district since 2001.

Table 4: Year wise trends in number of doctors in Kalahandi district

Year	Sanctioned posts	In position	vacancy
2001	176	102	74
2002	176	103	73
2003	176	102	74
2004	176	100	76
2005	176	104	72
2006	176	104	72
2007	176	108	68
2008	176	109	67
2009	180	100	80
2010	187	119	68
2011	176	131	45
2012	176	134	42

(Source: from CDMO office)

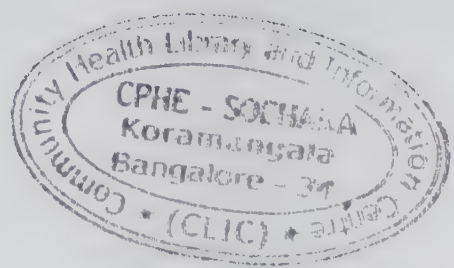
We find that firstly, there has been no change in the number of sanctioned posts for almost a decade, since 2001. (We do not know why the number of sanctioned posts was increased in 2009 and in 2010.) The incentives were introduced in 2006, and from 2006 to 2010 onwards there has been only a marginal decrease in the number of vacancies, from 72 to 68, and then it is seen to have decreased to 42. We have another set of figures from the NRHM data for 2011 January, which give an idea of the existing state of affairs, and which can possibly explain the decrease in the vacancy from 68 to 45 in 2011 (Table 2).

Table 5: Summary of Vacancies at each level in Kalahandi district (from HMIS data as of 31/1/2011)

Category	S	P	V
Joint Director (JD)			
-I(General)	1	1	0
JD-I(special)	5	5	0
JD-II (General)	6	3	3
JD-II (Special)	14	10	4
Senior-I (General)	35	30	5
Senior-I (Special)	20	12	8
<b>Junior-I(General)</b>	<b>51</b>	<b>33</b>	<b>18</b>
<b>Junior-I(Special)</b>	<b>42</b>	<b>12</b>	<b>30</b>
Additional Post		22	-22
	174	128	46

We find that if the category of 22 Additional Posts, all shown to be filled, is deducted then the vacancies continue to remain at 68, at the 2010 level. Of these 22 additional posts (presumably created in 2011) nearly half are at the District Hospital, and the posted doctors are shown to be on unauthorized leave. Some are on study leave.

Tables 6 & 7 below show the continuing vacancies in all categories in the two incentive districts of Koraput and Kalahandi respectively. They also given an idea of how the government seems to be shunting around (adjusted) the available doctors from one institution. We could not explore why the government resorts to such measures.



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Table 6: Koraput - Vacancy Position of Medical Officers as on 22-12-2011(Summary)

	Category	sanction ed	posted	vacant
1	Joint Director (JD) I (General)	1	1	0
2	JD I (Specialist)	5	3	2
3	JD II (General)	5	2	3
4	JD II (Specialist)	14	14	0
5	Class I (Senior) General	35	29	6
6	Class I (Senior) Specialist	19	10	9
7	Class I (Junior) General	55	41	14
8	Class I(Junior) Specialist	33	16	17
9	Additional	1	1	0
10	Additional	1	1	0
	Total	169	118	51

(Source: HMIS data from NRHM)

Table 7: Kalahandi – Staff position in CHCs as of January 2012

(Source: personal communication CDMO office)

	facility	Sanctioned posts		Current position				vacancy	
		MO	Specialist	MO		specialist		MO	specialist
				Contractual	regular	contractual	regular		
1	CHC Borda	1	2	0	0	0	0	1	2
2	CHC Parla	1	1	0	1	0	1	0	0
3	CHC Pastikudi	1	2	0	1	0	2	0	0
4	CHC Kesinga	1	4	0	1	0	4	0	0
5	CHC Junagarh	1	4	0	1	0	4	0	0
6	CHC Chiliguda	1	2	1	0	0	1	0	1
7	CHC Narla	1	4	0	1	0	2	0	2
8	CHC Thuamal Rampur	1	4	0	1	0	2	0	2
9	CHC Chapuria	1	2	0	1	0	0	0	2
10	CHC Kalampur	1	1	0	1	0	1	0	0
11	CHC Bishwanathpur	1	4	0	1	0	0	0	4
12	CHC Lanjigarh	1	2	0	1	0	1	0	1
13	CHC Jayapatna	1	4	0	0	0	4	1	0
14	CHC M Rampur	1	4	0	1	0	4	0	0
15	CHC Koksara	1	4	0	1	0	1	0	3
16	CHC Karlamunda	1	1	0	1	0	0	0	1

We find that of the 16 CHCs in this district only 7 have specialists shown as posted; the remaining have vacancies. One CHC - CHC Borda - has no doctor at all -neither MO nor specialist. While 2 CHCs had no MO, in all 12 PHCs had no MO.

While these are the figures given on paper our experience was that even in some of those CHCs where specialists are shown as posted, there were actually no specialists. Or the specialist was also the MO-IC and had to handle all the administrative work. Or the doctor was on PG study, hence not available at the facility. Hence the official figures showing doctor posted need not necessarily mean that the doctors are all available at the facility to provide the services.

It was told to us in the non-incentive district that situation similar to that in KBK districts prevails in other districts of Orissa. In fact, according to a very senior level health official, shortage of doctors was worse in the other districts (non-KBK districts). Some doctors, including one at a very senior level, mentioned that it was not correct that there was a shortage of doctors. We were told that every year around 400 graduates were passing out; that makes it around 12000 doctors in all over the past 30 years. How can there be a shortage when the government health services did not require more than 6000 doctors in all? Doctors were available, but



were not joining government services due to the above-mentioned problems of lack of infrastructure, poor service conditions, harassment, etc.

Indeed, the vacancies in several non-KBK districts are as much as or even higher than that in the incentivized KBK districts (Table 8).

Table 8: Percentage vacancies across districts of Orissa as of January 2011

	District	% vacancies
1	Angul	36
2	Balasore	18
3	Bargarh	21
4	Bhadrak	16
5	Bolangir	7
6	Boudh	25
7	Cuttack	16
8	Deogarh	20
9	Dhenkanal	26
10	Gajapati	-7
11	Ganjam	9
12	Jagatsinghpur	28
13	Jajpur	26
14	Jharsuguda	28
15	Kalahandi	12
16	Kandhamal	26
17	Kendrapara	23
18	Keonjhar	2
19	Khurda	10
20	Koraput	23
21	Malkangiri	40
22	Mayurbhanj	-4
23	Nawarangpur	34
24	Nayagarh	24
25	Nuapada	23
26	Puri	19
27	Rayagada	14
28	Sambalpur	1
29	Sonepur	3
30	Sundargarh	17

(From NRHM HMIS data obtained by personal communication)

As was pointed out to us during the discussions, in coastal districts of Balasore, Bhadrak, Jagatsinghpur, Nayagarh, Kendrapara, Puri, (the regions of Orissa that are considered to be better developed than the southern KBK districts), and the western orissa districts like Bargarh, Boudh, Jharsuguda, the vacancies are comparable to or even higher than those in the KBK districts. In some like Angul and Boudh the

vacancies are much more; with Angul, a district in Northern part located closer to the capital city, having a very high percentage of vacancies (36%), next to that in Malkangiri, a KBK district.

Table 9: Percentage vacancies at Junior and Senior level positions across some districts of Orissa

	District	Jr.I (General)				Jr I (Spec ialist)				Sr I (Gen)				Sr I (Specialist)			
		S	P	V	%V	S	P	V	% V	S	P	V	% V	S	P	V	%V
1	Anugul	33	10	23	70	18	3	15	83	32	25	7	22	38	18	20	53
2	Mayurbh anj	97	86	11	11	63	52	11	17	56	46	1 0	18	29	24	5	17
3	Boudh	12	11	1	8.5	8	7	1	12. 5	14	11	3	21. 4	12	8	4	33. 3
4	Sambalpu r	36	26	10	28	25	14	11	44	39	35	4	10	21	10	11	52
5	Bargarh	48	32	16	33	27	11	16	59	27	22	5	19	21	12	9	42
6	Sundarga rh	71	62	9	13	50	18	32	64	45	42	3	7	12	3	9	75
7	Jharsugud a	18	15	3	17	11	3	8	73	16	13	3	19	12	4	8	67
8	Balasore	74	47	27	36	40	17	23	58	34	30	4	11	13	8	5	38
9	Bhadrak	53	35	18	34	24	13	11	46	16	8	8	50	12	8	4	33. 3
10	Cuttack	81	67	14	17	43	16	27	63	52	39	1 3	25	24	16	8	33. 3
11	Jagatsing h-pur	40	25	15	38	24	6	18	75	23	16	7	30	12	4	8	67
12	Khurda	52	45	7	13	32	16	16	50	25	20	5	20	12	8	4	33. 3
13	Puri	59	42	17	29	44	15	29	66	31	24	7	23	9	8	1	11
14	Kendrapa ra	49	24	25	51	28	16	12	43	18	10	8	44	12	7	5	42
15	Keonjhar	70	64	6	8	43	32	11	26	40	34	6	15	22	11	11	50
16	Kalahandi	51	33	18	35	42	12	30	71	35	30	5	14	20	12	8	40
17	Koraput	56	39	17	30	33	9	24	73	35	27	8	23	19	7	12	63
18	Rayagada	44	39	5	11	21	5	16	76	24	19	5	21	21	12	9	43
19	Malkangir i	29	22	7	24	17	6	11	65	17	12	5	30	13	6	7	54
20	Nayagarh	45	15	30	67	30	12	18	60	18	10	8	45	12	7	5	42

(From HMIS data obtained by personal communication)

A simple computation of vacancies at the Junior - I (entry level) and Senior - I level (largely the categories that are posted in the peripheral institutions of CHCs, PHCs)



across all the districts shows that the shortage of doctors at this level too is prevalent all over the state (Table 9). As in the case of all posts, the vacancies in several non-KBK districts are as much as or even higher than that in the incentivized KBK districts. In some like Kendrapara and Anugul the vacancies are much more; with Anugul, a district in Northern part located closer to the capital city, having a very high percentage of vacancies, of the order of 70% at the Junior-I level and 53% at Senior-I level for general doctors.

Overall, at the state level, the vacancies at present in different level of posts after restructuring of OMS Cadre are Junior Class 1 (Specialist)– 658/1158 – 57%, (Non Specialist) 576/1076 – 54% , Senior Class 1 – 835/1440 – 58% (figures from [www.omsa.in](http://www.omsa.in)). While these are the figures on paper, one needs to bear in mind the other reality of 'shown posting' – namely those shown as posted may have been deputed to higher institutions, or may have actually used influence and bribe to work elsewhere, and may not necessarily be reporting and providing services in the peripheral facility. For instance: in Kalahandi district, of the 128 who are shown as posted, 19 are reported to be unauthorizedly absent, 3 doctors have submitted their resignation, and 10 have gone for PG studies; this leaves in all only 96 actually in the facility. Similarly, in Mayurbhanj more than 10 of the doctors shown as posted are on leave for PG study.

Further, the lack of specialists is uniformly acute across all the districts listed above. It is expected that the vacancies in specialist posts will only increase when All-India Entrance Examination for PG examination begins, as the in-service candidates will not be able to qualify as they are overburdened with duties and have little time to study.

*It also emerged that the doctors would prefer to work or be posted in, or in a place close to their native district for various reasons. In Mayurbhanj this was the case – several respondents doctors belonged to the same or neighbouring districts. Whereas in the KBK districts only two of the 20 respondents belonged to those districts; the rest were from other districts. This is a reflection of the fact that in the government health services itself the proportion of doctors from the KBK districts is very small. Our estimate shows that of the 3000+ doctors in the government health services shown to be posted as of December 2011, hardly 8 per cent in all are from the 11 KBK districts, such as Rayagada, Koraput, Kalahandi, Gajapati (Table 10). The actual number of doctors from each of these districts is less than 50. Whereas, 19 per cent are from a single district - Cuttack. We could not get information on the proportion of doctors belonging to the tribal communities from these regions; however available information indicates that they are a tiny proportion of the small proportion from these parts. This points to the gross regional inequities in the state – why is it that over the past decades there have been such few doctors from these areas? Is it that young people from these areas are not having access to good educational facilities that can make them eligible for higher studies such as medical education?*

Table 10: Native district of doctors in the government health services December 2011

	District	No of doctors from this dist. in government health service
1	Cuttack	640 (19%)
2	Ganjam	478 (14%)
3	Balasore	401 (12%)
4	Sambalpur	260 (7.7%)
5	Puri	175 (5.2%)
6	Sundargarh	153 (4.5%)
7	Jajpur	146 (4.3%)
8	Bhadrak	140 (4.1%)
9	Dhenkanal	119 (3.5%)
10	Mayurbhanj	117 (3.5%)
11	Kendrapara	105 (3.1%)
12	Bolangir	92 (2.7%)
13	Jagatsinghpur	92 (2.7%)
14	Keonjhar	85 (2.5%)
15	Nayagarh	63 (1.9%)
16	Kalahandi	41 (1.2%)
17	Koraput	39 (1.1%)
18	Angul	34 (1.0%)
19	Bargarh	34 (1.0%)
20	Jharsuguda	32 (0.9%)
21	Kandhamal	25 (0.7%)
22	Gajapati	22
23	Boudh	18
24	Rayagada	16
25	Deogarh	11
26	Nuapada	9
27	Sonepur	4
28	Nabarangpur	3
29	Malkangiri	1
	TOTAL	3,355

(From the list of OMS cadre doctors available on: [http://www.orissa.gov.in/health\\_portal/index.html](http://www.orissa.gov.in/health_portal/index.html), downloaded in February 2012)

It has been pointed out by others too that because "the state has neglected these areas (KBK districts) for very long time, there are very less number of local people. Doctors from costal and other parts of Orissa are not keen to come here despite the incentive. 'It is time to have some reservations in state medical colleges, as a long-term plan, for the people of this region so that they can be retained in the area. Government should create additional seats for the people of this region. Some seats (10% to 20%) should be reserved for the remote area and the students of those areas selected by the community through PRI should study MBBS and ensure that they will serve their own place throughout their career" (Padhi 2006)



## 5. Operational issues in implementation of the incentives scheme

“Incentive is conditional, renewed annually”

In order to get the incentive the Medical officers (MOs) in charge of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Area Hospitals have to furnish a certificate every month to Chief District Medical Officers (CDMOs) certifying whether the concerned doctors in their administrative area have stayed and provided services in the respective institutions throughout the month. Surprise visits are to be made by CDMOs to verify whether the MOs have been physically present in the health institutions. In case a doctor is found to have made incorrect statement regarding his or her attendance, the incentive amount is to be recovered from the countersigning officer. The district collector, who is responsible for administration of the district, is supposed to regularly monitor the attendance of doctors. The CDMOs, in their fortnightly confidential report to the collector, is to incorporate information regarding absenteeism (See Annexures I & V for the notification on incentives).

If a doctor goes on leave for more than three days or is in transit on account of transfer, he or she does not qualify for incentive. “Incentive amount is conditional – the doctor had to reside in the HQ facility (PHC or CHC or SDH or DH as applicable) to get the incentive; but often it is not possible to live in the place where the facility is located. Even rented accommodation is not available in some towns or villages where PHCs and CHCs are located. Further, they could not avail of leave beyond the regular entitlement to get the incentive. The concerned MOs had to write to the CDMOs to get the incentives sanctioned”.

“Incentives are not added to salary; have to pay bribes at different levels to get incentives and other official benefits”, according to a senior level district health official.

One doctor pointed out that incentive was not like the salary; the decision to give incentive was reviewed every year, and the renewal letter does not come on time. So there were delays in getting the amount, and they did not receive it regularly on a monthly basis. The incentives are not regularly paid to them by the government and even they are not aware whether or not the scheme is in place, and whether or not they would be getting the incentives.

Many doctors said they did not receive incentives regularly. Many had not got the incentive amount for several months, for as long as more than 6 months. Some had not got it at all in 2011; they said it had not been sanctioned. There seemed to be a lengthy procedure to get the incentives sanctioned – the application had to be verified by the ADMO, and then counter-signed by CDMO; and then it was sent to the DHS for releasing the amount.



There seemed to be lack of proper information among the doctors we met regarding the conditionalities for receiving incentive. While most doctors said that one condition was that they had to reside in the headquarter (institution of posting), some said that the CMO had some discretion and could sanction it if a doctor was not residing due to unavailability of residential accommodation at the headquarter. Similarly, there seemed to be no clarity regarding incentive for leave period and length of absence from headquarter. Some said that if they were away for more than the stipulated days of casual leave, then they did not receive any incentive at all for the entire month. While others said that an amount corresponding to the number of days of leave taken was deducted and they received the rest. We were also told that there are instances where “doctors who do not stay at the headquarters also get incentives”.

There appeared to be no clear guidelines on what is to be done if house was not available in the headquarter area, or if a doctor took more than 3 days’ leave. However, we were also told by some doctors that the sarpanch could certify that accommodation was not available for the doctor to stay at the headquarters, and that would relieve the doctor of the conditionality of having to stay, and he could then get the incentive.

A perusal of the government orders on the incentive scheme points to the source of these irregularities, uncertainties and lack of information among the doctors. The financial incentive was first announced in 2006 for a year; since then it has been reviewed every year, and sanctioned for one year at a time. The most recent order issued in January 2012 (Annexure V), begins by referring to chronic absenteeism of doctors in KBK and KBK+ districts, and says that the government has decided to grant financial incentives to regular MOs in order to ensure MOs join in these districts. It goes on to admit that several orders and instructions have been issued in this regard, since 2007, and that this specific one supersedes all the previous orders in this regard. After all this build-up to expectations of some substantial step, one finds that there is no basic change in the premise or the instructions for giving incentives - the incentives are to simply continue as before. Once again as per the latest government order, the monthly incentive, of Rs 8000/- for doctors in periphery and Rs 4000/- for those in DH and SDH, will be available for a period of one year, from August 2011 to July 2012. This is subject to ‘review by Government and further concurrence from the Finance Department every year’, and will be then communicated to the CDMOs.

## 6. Impact of NRHM

Some doctors felt that there had been some improvements due to NRHM – some infrastructural improvements, some funds are made available; so are para-medical staff – such as nurses and laboratory technicians for conducting tests for malaria and tuberculosis diagnosis, as well as AYUSH doctors. There was some additional staff from NRHM, such as those in the Block Programme Management Units (BPMUs), who were getting easily recruited without much procedural delays.



However, this appears to have come at a certain cost. According to one doctor, as MO-IC he was involved in administrative work most of the time – in attending meetings, trainings, supervision and monitoring. He had no time now for clinical practice. Another doctor felt that 'NRHM has not helped much; some financial improvements. Specialists were being made to look after NRHM work; other officials were insulting and rebuking them. We should not be attending meetings, the number of which has increased after NRHM'. "NRHM needs to be separated from the clinical jobs. I am signing 500 forms everyday; nobody wants to take responsibility for all this. Have to look for land for sub-centre. Why do all this? While it has been good and some funds have become available, there is overload and a great burden. Need to have a separate structure for it", felt one MO IC of a CHC.

**"Multi-skilling is killing us; the body works but not the mind. It is killing the health system: having fewer skilled doctors and many unskilled workers.** We continue to work because of insecurities. Why should DPM-BADA (District Programme Manager, Block Accountant cum Data Assistant) not handle all the administrative work? The administrative and technical tasks should be separated: administrative work could be done by non-medical persons, while doctors could be consulted on technical issues", was the response of another doctor, a paediatrician.

One doctor, officiating as the Senior MO at a CHC in the incentive district, had this to say: "After NRHM, I am not a doctor anymore. 90 % of the time is spent on implementation of NRHM programmes – ASHA-ANM-AWW training; paper work, administrative work, field work, attending meetings with BDO, CDMO, sector level and monthly nodal meetings; have to prepare for these meetings; and there is a lot of paper work. There are 8 vehicles here and I spend an hour every morning in managing them. Why should I be doing all this? Why can there not be a non-medical person, maybe an MBA for all this work. Let the BPO or BADA do overall supervision and management. *I am a doctor; our clinical skills are not used. Don't give us incentives, but employ one person for all this work. Let us take care of patients. When will I learn, read, update my knowledge? Through NRHM they are killing a doctor, reducing our skills. I am not able to spend time with other doctors*".

Thus, there were bitter complaints about the increase in administrative work due to NRHM. One doctor said that NRHM was planning to improve facilities, which is what the doctors too wanted. However, they wanted to be involved as doctors. Shortage of doctors in peripheral areas affected NRHM programs. The DPMU staff was working sincerely, however there were vacancies in the DPM too. The retention rate of DPM staff too was very low; their contract was renewed every 11 months. Only one doctor said NRHM work was not an "over-burden, there was supervisory work, it had its own staff, BPO, BADA, etc". This particular doctor was located in a CHC where other doctors were present to attend to OPD and the patients.

While RKS funds are available for minor repairs, however, Rs 50,000 a year was inadequate and could not be used to solve all the problems. For instance: in one PHC the doctor told us that the RKS attendant – a sincere fellow who worked for Rs 80 a day - had to be paid regularly and that itself took away nearly half the amount of Rs 25, 000, leaving little for other expenses.

One doctor felt that AYUSH doctors are a burden to the health system; there should be separate hospitals for them. They do not want to reveal that they are AYUSH doctors; they did not prescribe AYUSH medicines, which were not being used and were being wasted.

Several doctors said that PPPs would not solve the problem of shortage of doctors. When specifically asked, they said they would not join a facility run by an NGO. The NGO – run PHC that we visited in one of the incentive districts had an elderly private practitioner from the district headquarter town, who was staying in the PHC premises. The PHC had been given to the NGO in 2008 for three years, and was to be evaluated after three years. Like other PHCs, this PHC too was lacking in infrastructure, and water and electricity. Three doctors had come and left. The NGO had also not received funds since the previous four months.

## 7. Issues other than improvement of infrastructure and service conditions

“I have been working sincerely; there is no appreciation of our contributions, of all the work we do; there is no system of assessment, no forum or mechanism to address all this”.

Several doctors were bitter about the role of the bureaucracy that was positioned in the capital city and played around with their entitlements, such as salary increase, transfers, promotion, etc. They felt that there was stagnation of health services due to the bureaucracy. “Affected people are not consulted; schemes made by clerks, bureaucracy”.

The lack of transparency in the selection process of the Orissa Public Service Commission (OPSC) for the Orissa Medical Service (OMS) was pointed out. We were told that questions irrelevant to medicine and medical practice were asked at the oral examination by a panel that comprised of more non-medical people than medical professionals. There was also never any response on the OPSC Helpline that was advertised on the web-site. A lot of time had to be wasted to get any information or response from them. There were also issues with allotment of seats for general and reserved category applicants; at times seats from the general got transferred to the reserved category. One doctor said he had not been selected in the general category, but got through in the reserved category.



A group of doctors, who have been in service for more than twenty years, felt that "It takes a long time to get all the qualifications and become a doctor; a single MBBS doctor is superior to many other posts; this is not accounted for in pay structure. Even a lecturer is paid more than a doctor. There is much disparity between us and other professionals; no acknowledgement of the greater tasks and responsibilities; lower status than OAS (Orissa Administrative Services) and judiciary, where the people are less qualified than us.

The atmosphere is not conducive for working – we face interference and ill-treatment from PRI members, harassment by public, by CDMOs, political interference. Doctors are pushed to the margins - PRI (panchayati raj institutions) and bureaucracy are spoiling this noble profession.

When asked about specific instances of harassment, we were told that there was interference in issues such as distribution of LLIN (long lasting insecticide treated bed-nets) under the malaria control programme, in ASHA selection; if the patient is in a far-off place and ambulance is not available to transport to DH there is pressure to transfer patient to the CHC, where adequate facilities are not available to give treatment, and the patient has to be sent to the DH. "Certain people, like MLAs-journalists expect us to go home and treat them".

One young doctor, already frustrated and de-motivated, remarked "good, positive aspects about our work are not highlighted or recognized only negative things are emphasized. When patients abuse and assault us, we have to listen patiently to them; however when we so much as scold a patient then there is an outcry. Due to lack of doctors, at times we have to attend to several patients; if we are taking care of one and not paying attention to another, we are hauled up and told we are not working".

A young doctor in the non-incentive district, who expressed a desire to provide some services to those who came to the facility, was however frustrated by the abject conditions in the PHC he was posted to. He said that he had done well in his school and was a topper; had opted to become a doctor and then joined the government health service. However, the situation here was so bad; he was much poorly off than his school and other college mates in the city, he did not even have a proper place to live in, leave alone better salary. He said such things – question of achievements, recognition, in comparison with peer group – do arise and did matter.

Some other tasks not very evident were pointed out as increasing the work-load. Such as: increasing number of post-mortems to be carried out in centres designated as post-mortem centres, attending courts in MLCs; one doctor remarked that over his 14 years at the health facility he had made around 200 trips. Another doctor, a pediatrician was indignant – "Pediatricians should not be doing medico-legal cases".



According to one doctor, “There is deterioration in quality of teaching nowadays; clinical skills getting blunted by multi-skilling; lack of clinical acumen and clinical skills. Young doctors do not want to work for the poor and the underprivileged. Important to have value-based education”; he felt that the kind of education he received had guided him and instilled in him a sense of service and commitment to people.

*It was also told to us that, apart from the routine work-load at their health facility, these government doctors also had V.I.P and Protocol duty, which included testing of food to be consumed by V.I.Ps, when the latter visited the districts. This came across as an absolutely antiquated procedure, and there can be no place for such practices in a modern, democratic societies, and need to be stopped.*

We came across an instance where a doctor was booked under the Prevention of Atrocities on SC/ST Act. The cause for this being that in a case of a patient brought in with head injuries and fractures after being attacked by a bear, they offered preliminary treatment and then advised the relatives to take him to the DH for CT-X-Ray. The relatives and some others around got agitated and following a heated argument, the doctor complained against them for interfering with treatment and obstructing his work. In retaliation they filed a complaint against him under the above act.

This provides a concrete illustration of what another doctor pointed out: “people from the area came with expectations of good service. If it is not available they get angry with us; it is important to provide basic services”.

We find that, increasingly, doctors are assaulted or abused by patients’ relatives whether it be urban areas or rural. In big public hospitals in urban areas often resident doctors are expected to provide treatment, often life-saving emergency treatment as well as handle agitating crowds; in peripheral areas it is inexperienced doctors or a single doctor in the facility. As pointed out by others, “By and large, inadequate facilities, bad working conditions lead to friction and even hostility between doctors and patients; and doctors are presented by an opportunistic media as being irresponsible and rude” (Madhwalla and Roy 2006).

#### 8. Impact of area being declared as left-wing extremist affected

All the 8 KBK districts, along with several non-KBK districts, have been declared as left-wing extremism affected districts (LWE district), and receive special, additional grants from the central government under special schemes for such areas. These relate to security related expenditure and the Integrated Action Plan (IAP) of the Planning Commission floated in mid-2010 (See Foot Note 2 in earlier section).

We asked the doctors about the impact of extremist activities, whether there were any specific problems, whether their functioning and the functioning of the health



services was disrupted in any way, whether that was a factor influencing decision to not work in these areas.

With a rare exception, all doctors told that they had not faced any problems on this count, that health services were not disturbed in any way due to their presence. According to one MO drivers did not want to go to the villages due to insecurity and the road blocks that were sometimes put up by naxalites.

“There was no violence or threats or problems of any kind, although it is categorized as a maoist affected area”. “Naxals do not disturb us; we move around freely, there is no problem”. Another doctor mentioned that when the naxals called for a blockade, communication and goods supply was affected. When asked whether this affected supply of medicines and vaccines he said that such supplies were not affected. When asked whether field workers were affected in any way it was told that some people posing as naxals once tried to scold a health worker and extort money; however the naxals do not do such things. Facilities located in areas bordering neighbouring states (Chhattisgarh and Andhra Pradesh) too had not faced any problems. Several doctors told us that doctors and health workers were not harmed in any way and were actually respected by them. In one facility where a television was on the doctor remarked that the media was creating terror among people in cities about such areas by continuously portraying these as maoist-affected. However, many people had been living here for several years and had not been harmed in any way.

According to one doctor, there was no naxal problem; the problems were those of ignorance of the people, harassment by influential people, violence and abuse from relatives of patients who could not be treated here due to lack of facilities (as mentioned above). Another doctor pointed out that ANMs were harassed by drunkards. In another CHC we were told that at times drunk men loitered into the premises and asked for money; having a security guard at the entrance to the premises may be of some help in tackling such elements.

#### View of NRHM staff regarding incentives

We had an opportunity to talk to some NRHM staff in one of the districts. One of them said, “in the monthly meetings MOs say that they are for medical work; but are being used for administrative work. To improve the quality of services we need one more MO. MOs have to attend to OPD; are not able to give time for implementation of programmes. Even if incentive is given, doctors will not stay if infrastructure is not improved”.

According to another NRHM functionary, who has worked for more than five years now, NRHM staff is supposed to work with doctors who are meant to be administrators because of their designation. This has its strengths and weaknesses. While the clinical skills are a resource in training, there are constraints in the communitization component, such as in RKS, GKS, etc. All this affects the



programme, and both components suffer. The doctors are told – you have to spend Rs 1 crore; the doctors say we are not administrators. The problems are more at the field level, among the peripheral MOs. The load of work is on the lower level functionaries, who have to be supervised by MOs. The MOs have extensive supervisory role; have to look after all field level activities. This is splitting the MOs, they are agitating, not willing to become MO-ICs; NRHM work being done unwillingly. From CDMOs to ADMOs all are complaining. MOs are demanding incentive for NRHM work.

While the doctors of the state health service (DHS) felt that some staff had become available due to NRHM, ironically one programme manager felt that there was a human resource problem within NRHM too; not enough staff was available and there was inequitable distribution of staff. Same number of staff was available for all districts, not taking into account variations in the size of the districts. .

There is conflict between the regular staff and the contractual staff under NRHM. NRHM staff is vulnerable and not being treated properly, with dignity; some reported being referred to as “bloody contractual staff”, ‘NRHM wallahs’. These problems are not being addressed. There was no mechanism to retain, mechanism only to retrench. The emphasis always was on somehow getting the work done, on output. The work culture was very poor and there was too much stress; overall the work environment was de-motivating and disheartening. “We are working because of personal motivation, no support from the system. Need to be looked upon as a support unit, not as a parallel system’.

#### Our Observations regarding physical infrastructure of health facilities in all districts

There is wide variation in the quality of infrastructure – some CHCs/PHCs were located in miserably derelict buildings, while in some the new buildings had been or were being constructed, with NRHM funds. In several facilities construction of buildings for OPD, IPD, labour room, wards, waiting rooms, was visible. In some instances the buildings had been constructed but were lying locked up and had not been handed over for use. The living quarters where available were just not adequate in number and not very satisfactory according to the doctors, but they were using them due to lack of alternative accommodation. Some simply stayed in the facility itself. The condition of the PHC buildings especially was deplorable. Often they were in an absolutely dilapidated condition, had asbestos sheets for a roof, with no proper electricity and water supply, and the doctors were managing somehow. They were not in any livable condition. Some of the facilities we visited were in valleys, surrounded by the forested hills.

Not a single facility, CHC or PHC, had all the staff, laboratory, and other facilities that it was supposed to have. Few were equipped under the NRHM and had contractual lab technicians for detection of malaria and tuberculosis. Several CHCs had been declared to be FRUs but with no facilities. At one CHC the doctor pointed out they had an ICTC for HIV-AIDS, but there was no lab facility; how were they expected to carry out the



test for HIV? The appointed counselor only gives information and counseling about RTI-STI. None of the CHCs had basic laboratory and x-ray facilities; not all had in-patient facilities although most of the doctors reported carrying out deliveries on a regular basis.

The facilities we covered were largely were between 50-100 kms away from the district headquarter. Motorable roads (state highways and roads under the Pradhan Mantri Gram Sadak Yojana) were available to reach all CHCs and nearly all PHCs; roads were being repaired in many areas. Some of these roads went through dense forests. The PHCs were mostly located between 25-50 kms away from the CHCs. There were PHCs and SCs that did not have all-weather roads and were difficult to reach even in normal times by jeep or SUVs. However, as far as the doctors were concerned the problem was lack of transport facilities, public and private. We did not see any buses or other vehicles such as SUVs and jeeps carrying passengers plying on the roads while we were travelling; there would be long stretches when ours was the only vehicle moving on the road. This was a problem pointed out by many doctors in the incentive district – that there were no means of transport and they had to make their own arrangements for travel.

Officials at the State Human Resource Management unit told us that to address the problem of living accommodation the government was in the process of making arrangements to provide quarters in the Block Cluster Housing schemes. This may be of limited use for doctors posted in or in the vicinity of the block institutions; transport arrangements may have to be made for those posted in the surrounding PHCs. Not to mention that such an arrangement means that doctors will not be available in the PHC at all times. The CRM report of 2011 mentions that 'the state has a shortage of residential accommodation for staff at facilities. Staff quarters are mostly available at DHH, SDH, CHC & PHC level. However, these are not adequate to provide accommodation to all staff (Government of India 2011).

### **SECTION III: DISCUSSION: THE BUCK STOPS HERE.....**

What emerges from this qualitative case study is that a section of medical graduates in Orissa is joining the government health service. We were told by all the young doctors that roughly around 30-40% from their batches joined the government service; although not all may be staying. However, it was not the monetary incentive that was the motivating factor for joining the government health services. According to all the respondents, doctors are not joining, nor are they staying because of the monetary incentives, but are doing so due to a variety of other reasons, as described above.

The picture that emerges clearly indicates that there is more to unwillingness of doctors to join the government, than just the 'backwardness' of a region; that even in the districts that are relatively more developed, that do not have tribal populations,

there are large vacancies, of both general and specialist doctors. It was mentioned that because of the policy of compulsory posting for five years in KBK districts after joining government service the situation was better there compared to the other parts of Orissa, that other regions were being deprived of doctors. This argument loses sight of the larger reality that the total number of doctors opting to join the government service is itself decreasing. It also misses the reality that by merely having a policy of compulsory posting the government has not been able to ensure the actual presence of doctors in the peripheral institutions in the KBK region. Therefore, it has introduced monetary incentives in the hope of persuading doctors to stay put and provide services. Even that has not been very effective in addressing the problem.

The above responses of the doctors, from both incentive and non-incentive districts, starkly bring out the reality of why doctors are unwilling to join, the reasons why they join, and why measures such as PG related inducements and monetary incentives are inadequate ways for getting doctors to join and work in the government health services. Even the PG related measures, such as reservation of PG seats for in-service doctors, is of limited use, as the acute shortage of specialist doctors starkly highlights – few doctors seem to be joining after PG.

That financial incentives introduced in 2006 for doctors in KBK areas have not had any significant impact on attracting and retention of doctors is evident from the available information on availability of doctors and the testimonies of the doctors, and what we saw in the field. To a limited extent, reservation of seats for post-graduation for in-service doctors is a factor influencing decision to join, at least for the fresh graduates. But that is of limited use as far as the health system is concerned, as the positions become vacant once the doctor leaves on getting admission to post-graduation.

The 5<sup>th</sup> Common Review Mission (CRM) report for 2011 corroborates our findings. According to this report special incentives being dispensed for staff in KBK districts are not attracting suitably qualified staff, in absence of a long term assured career progression opportunities (Government of India 2011). The other relevant observations of this CRM are as follows:

- There has been little change in the position of regular medical officers between 2005 and 2011 [3457 (2005)/ 3575 (2011)]. (See Table below) (Government of India 2011 pp 35-36)

<i>Position</i>	<i>Requirement as per IPHS</i>	<i>Sanctioned strength</i>	<i>In Position</i>	<i>Vacancy against sanction</i>	<i>Vacancy against IPHS 2010</i>
Specialist		1819	1123	696(38%)	
Medical Officer	6422	4394	3853	541(12.3%)	2569 (40%)



- Low expenditure was reported against additional incentives for MOs at CHC / PHCs.
- Vacancy in positions of ADMO at DHH and SDH was impeding the implementation of the NRHM programme effectively.
- The non-availability of medical officers and specialists was adversely affecting the health services delivery at First Referral Units (FRUs) in the district, resulting not only in shrinking of the range of services available across the health facilities but also reducing the number of facilities that can provide the all the components of health services mandated at FRUs.
- While difficult area allowances were being provided to the health service providers, however interaction with the medical officers brought up many issues which were causing dissatisfaction among them.
- Most medical officers posted in difficult areas continued to be posted in these areas for years, with no avenue for transfers.
- Promotions took a very long time, with most of the doctors getting the first promotion after 20 years of being in service, and most of them retiring within two promotions at the most.

The CRM notes that “The State has made good efforts to expand its HR base by creating new posts and recruiting health personnel against various cadres through contractual staff. However the gap between “needed” and “available” is immense. This is especially seen in the case of specialists (Anesthetist & Radiologists), MPW (M), Lab technician etc”.

So, as far as the ‘effectiveness’ aspect of incentives – monetary and non-monetary - is concerned, it appears that such measures have an extremely limited impact, if at all. Our findings and the government’s own figures and findings indicate that together all these measures have not been very effective at improving availability of doctors in peripheral institutions. At best they get in a few doctors to implement some programmes, howsoever half-heartedly. But, given the present deplorable status of the health infrastructure in the state, by themselves such measures are a gamble - they can never provide the full range of doctors required to effectively run the health facilities and provide rational and good quality health services.

We found that the cluster housing scheme has not been fully implemented, and housing was still not available for the all the doctors and other health staff. This observation is corroborated by the observations of the 5<sup>th</sup> Common Review Mission (CRM) of NRHM that the state has a shortage of residential accommodation for staff at the facilities. Staff quarters were mostly available at District Headquarter Hospital, Sub-Divisional Hospital, CHC & PHC level. However these were not adequate to provide accommodation to all staff (Government of India 2011).

Our respondents repeatedly noted that basic infrastructure (transportation, housing, etc.) and working conditions in most rural areas were unsatisfactory. Our



discussions and interaction with the doctors unequivocally indicate that **the central issues for the doctors were the unsatisfactory service and working conditions, poor infrastructure, and the overall backwardness of the region; the issue of monetary incentives was marginal and almost a non-issue. There is a very clear perception that if the conditions are not improved then even such incentives will not work.**

We found that some doctors had stayed largely due to personal reasons and have made some positive impact in spite of various difficulties and constraints, and especially used the small window provided by the NRHM. While these efforts are laudable and exemplary, however they remain individual efforts and will be lost when the individual leaves the system. One cannot read too much into it. Besides, emphasis only on individual efforts would be tantamount to missing out completely the forest for the trees – in this case the numerous systemic issues pointed out by most doctors.

*While there is a projection and hype that doctors are given monetary incentive as a recognition of the hardships faced in certain areas, in practice it is not very different from a 'dole' by the government given after monitoring and fulfillment of some conditions, and that too not given consistently and regularly. It appears to be more of a half-hearted and perfunctory response. In keeping it as a temporary measure subject to concurrence from the Finance Department on one hand, and on the other, not taking any long-term decisions to address genuinely the hardships faced by doctors in the field, and the manner of implementation, all together lend credence to the perception and resentment among the in service doctors, of discrimination and harassment by the bureaucracy, which they feel is comfortably located in the capital city, insulated from the harsh reality in the districts.*

The exact criteria for giving incentives to stay in the KBK districts is not very clear, except for the reason that doctors are not willing to go there to work. This study indicates that there are not very significant differences with respect to demography, terrain, socio-economic indicators and infrastructure, between Mayurbhanj, a non-incentive district, and Koraput-Kalahandi, the incentivized districts. Both areas share similar features, such as large tribal population and large population below poverty line, lack of employment opportunities, and lack of infrastructure. In fact, our respondents from Mayurbhanj pointed out that many regions of that district and in rest of Orissa are just as 'backward' as the KBK districts, and this has been corroborated by the vacancy situation. Yet, it is only the KBK districts that are perceived by the government and the doctors to be backward, and now there is the constant portrayal of it as being naxal-affected. If these are the reasons for doctors and other health personnel not wanting to work there, what are the reasons for the comparable or higher vacancies in districts like Angul, Boudh, Jagatsinghpur, etc? Why are doctors not willing to work in those districts? There is also the fact that most of the doctors are from the coastal districts that are considered to be more developed than the rest of the state; and they are generally



unwilling to join the public sector health services. In such a situation the government needs to re-consider the basis for classifying regions as backward, remote, and so on, and for adopting special incentives to motivate doctors and other health staff to work in such areas.

### **Why are doctors reluctant or unwilling to work in government health facilities?**

While the shortage of doctors may be particularly acute in parts of Orissa, but it is not restricted to one state, but afflicts the entire country, to a greater or lesser extent. Further, there is shortage not just in rural facilities, but districts hospitals and other public hospitals in urban areas too do not have the desired strength of doctors. Indeed, shortage of doctors and other staff has come to be accepted as one of the defining characteristics of public sector health institutions, as an inherent part of the problems of being a public sector, despite lack of well-researched and documented studies of quality of services in private sector that would shed light on human resources in private health facilities.

However, it has not always been the case that doctors have not wanted to **serve in hospitals and institutions in the public sector.**

*"The option of working in state and municipal hospitals was very attractive once upon a time. The cream of the profession competed to gain attachment to them. They served with devotion and sincerity, to bring themselves and their institutes, enviable reputations (Murlidhar 1993).*

It is well known and acknowledged that till the 1980s public sector institutions were at the forefront of setting high standards in medical education and practice; and individual doctors were motivated by ideas of service and maintaining high standards of excellence. That it is the public sector institutions for medical education and training that have provided the 'spring-board' for the growth of the private sector facilities across the country.

We find that while there is much lamentation over shortage and absenteeism of doctors, however, to address this problem it is not being asked *why the medical graduates are now not joining or are reluctant* to join public sector institutions, especially in rural areas. Where are the graduates and post-graduates who pass out each year from the state medical colleges going? Is there really a shortage of doctors? Why is there such an acute shortage of specialists? Why are there no doctors from certain regions and certain sections of society? We find that these are not the central questions in this issue of shortage of doctors.

## **What the discourse and policy measures on shortages of doctors for public health facilities in rural/remote areas address and what they ignore?**

### I. Individual Attitudes, Medical Education & Training

The discourse in policy-making circles on the shortage of doctors for the public health institutions in general, and especially those in the rural areas, has predominantly focused on the attitude of doctors, on the 'unwillingness', the 'disinclination' of doctors, educated and trained in western medicine in urban areas, to go to the rural areas.

"There are several reasons for the scarcity of qualified health workers in rural areas. The opportunity to earn a better income, to utilize skills, good living conditions, education opportunities for children and safe working and living environments are other important job attributes which tilt the balance in favor of urban location. .... For many medical graduates the desire for post-graduate specialization dissuades them from entering the job market and thereby the possibility of rural posting in the public sector. Once they have specialized, government employment and rural service is not attractive" (PHFI & NHSRC 2011 p 7, Rao et al 2011).

It is often argued that since medical students, at least in government medical colleges, get a highly subsidized education, the beneficiaries of this subsidized education must repay their debt in kind; that doctors have a moral obligation to provide healthcare to the society that paid for their education. In addition, medical professionals have an essential ethical obligation to help provide healthcare to the deprived, and so on. However, as some doctors have pointed out, "rather than simply expecting students to be ethical practitioners we must look at what prevents them from investing a single year of their lives towards rural healthcare delivery" (Kalantri 2007).

Since the 1970s the recommendations and strategies to remedy the inequitable urban-rural distribution of doctors in India have largely targeted the medical education and training of medical personnel, and have been guided by what kind of training is needed to provide primary level care; to have a different cadre, or a differently trained group, with the assumption that such people, trained differently, will stay and work in rural areas. There have been measures such as:

- Reform of the existing five-year curriculum by introducing community orientation, such as the Re-orientation of Medical Education (ROME) proposals of the 1970s.
- Various forms of compulsions, such as awarding degree after a period of service in rural institution, or admission to post graduation linked to a stipulated period of rural service, or a bond to work in rural areas after education.



- Leaving the present five-year MBBS untouched and introducing a totally new three year course, not unlike the earlier licentiate course.

As part of the health sector reforms, since the 1990s, additional measures have been proposed and implemented in certain parts:

- Letting the present five-year MBBS course be and training community health workers for delivering certain basic services in rural services.
- In-service training and multi-skilling, where existing health personnel trained with one skill set are being provided with other skills, so as to enable them to provide a larger range of skills. The most important and widespread use of this, has been the training of medical officers to provide emergency obstetric care including C- section surgery, and to provide anesthesia for supporting emergency obstetric care (life saving anesthetic skills - LSAS).
- Another form of multi-skilling has been to train and deploy doctors trained for four years in the indigenous streams of ayurveda, unani or siddha or in homeopathy to work as medical officers in primary health centers.

Some states such as Maharashtra opened medical colleges in rural areas, designed admission policies reserving a small proportion of seats for medical college applicants coming from rural areas, devised innovative programmes to expose medical students to the realities of rural healthcare, started community placement programmes, made rural placement a prerequisite for post-graduation, and penalized doctors for not fulfilling their rural bonds.

“Our experience in a medical college established in a semi-rural environment specifically to encourage community-based practice is that none of these strategies has been successful in encouraging medical students to stay and practice in rural areas. Students from rural backgrounds are as likely to practice in cities as are their urban-raised peers. The undergraduate rural experience is not associated with a greater likelihood of subsequent rural practice. Most students who complete community placement programmes do not find the rural stint personally enriching or professionally rewarding” (Kalantri 2007).

It has been also pointed out that, “Rural settings may lack appropriate mentors and students complain that they can neither acquire nor hone technological skills in a village. Unsatisfactory working conditions, lack of adequate staff and equipment, and primitive living conditions add to their woes” (Kalantri 2007).

While the appropriate pattern and curriculum of medical education certainly is an issue that needs to be discussed and re-formulated, that is not the only problem ailing medical education. As pointed out repeatedly by sections of the medical and public health community, another problem lies in the extreme commercialization of medical education and medical practice. Of the 335 registered medical colleges in India as of 2012 (as per Medical Council of India), more than half

are private colleges run by trusts. Most students admitted to these medical colleges are required to personally finance their expensive education. "Can we really expect students who have made what is essentially an investment to forget about money and think of their professional ethics and social obligations? After all, if students pay a fortune for their education they are going to be interested in recouping that investment at the earliest. By encouraging private medical colleges the government is sending the signal that medical practice is for personal profit (op cit). Identical concerns were raised by few of our respondents too.

"Is it realistic to demand social commitment from young doctors when nothing else in the system encourages them to think and act along these lines? Are they wrong if they think solely of their careers and turn a blind eye to the problems of a rural population with no access to healthcare?" (op cit).

*When asked whether he had raised the problems with his seniors, one young doctor in our study said their response was the following: don't think about the institution, think about your own self; pay some bribe and get out of the area, or out of the state; go for post-graduation; or join the private sector.*

Yet another problem is that of the commercial pressures on medical practice too. "For most medical students, the MBBS degree has lost its value because of the way in which medical practice works today, and the pressure to get a postgraduate seat is intense. Thus, even during internship, preparation for the MD entrance examination takes precedence over acquiring and honing clinical skills" (Kalantri 2007).

In such an overall situation of commercialization of both medical education and of medical practice, can individual policy decisions work without a larger qualitative change? Will compulsory rural service work? Can it work in isolation from the general trends in medical education and practice? "Can we force ethical practice by edict, or do we also need changes at the level of health policy to promote ethical behaviour?" (op cit)

It needs to be mentioned here that it is not entirely correct that the medical community has not been interested in the state of affairs. Sections of the medical community have attempted to raise problems affecting their profession as well as the larger public health system. There have been protests by doctors' groups not just against violence on doctors by relatives of patients. There have been agitations and protests for salary hikes and against fee hikes, against the mushrooming of private capitation medical colleges, against introduction of user fees in public hospitals, and against the overall privatization of health services.



## II. Governance and Management Issues

Shortage of human resources is also seen as arising from lack of governance and of improper workforce management policies. It is believed that most of the peripheral health centers are reasonably staffed with doctors and Auxiliary Nurse Midwives (ANMs); that there are less than 20% vacancies in these cadres; that the main issue is that large proportion of doctors and ANMs do not stay at the place (village or town) where they are posted; but stay in a larger city or town and commute to place of work. This makes their availability at place of work unreliable and limited, especially for emergency services such as skilled attendants at birth, including emergency obstetric care. So the problem is framed as one of lack of proper posting and transfer policies; that existing recruitment, posting and transfer policies are poorly implemented, in general one of lack of governance and lack of management (Mavalankar 2006).

In reality the situation is not as simple as is made out to be. The figure of 20 per cent vacancies is a gross underestimate, and actual shortages are much higher, as the situation for Orissa itself shows. Secondly, it is not entirely true that there has been neglect of HR management in the public health system. An Expert Committee on Health Manpower: Planning, Production and Management (Bajaj Committee) was set up in the 1980s to look into several issues relating to health manpower, including that of measures that would safeguard the career prospects of various categories of health manpower at the primary and intermediate level, and look into horizontal and vertical mobility. This Committee has a chapter dealing with health manpower management, and made the following recommendations vis-à-vis health manpower (Government of India 1987).

‘Management provides for mechanisms for the employment, retention, support and development of the health care personnel’. For retention the Committee recommended several measures to be taken to address issues of proper career structure, for promotion, living and working conditions, salary structure, etc. For instance it recommended that ‘Central guidelines be enunciated for a cadre planning, with promotional avenues both for vertical movement and a lateral induction based on seniority and merit. Salary structure should be the same all over the country. In order to remove the spatial distortions between rural and urban health services, incentives must be given by way of allowances, better living and working conditions and other fringe benefits to make the rural service more attractive’. Some of the other recommendations of this Committee are reproduced below:

- *Living and working conditions—inadequate living and working conditions in rural areas have led to the spatial distortions. These inadequacies increase the sense of isolation — both physical and psychological of rural health workers. In the overall planning, attention must be given to provision of adequate living and working conditions for optimal performance and job satisfaction of the rural health workers.*



- *Salary structure should be uniform for the same category, all over the country. In order to remove the spatial distortions between rural and urban health services, incentives must be given by way of allowances and better fringe benefits to make the rural service more attractive.*
- *Another important facet to be considered is the horizontal spatial mobility after few years of service in one region, so that the employee could look forward to posting in an easy area, when his family is growing up, so that he could discharge his duties towards his children more effectively.*
- *Logistic support - Especially in the underserved rural areas, it is essential to improve the communications to extract optimum benefit of the health care even in the remotest areas. The transport facility and availability of drugs and supplies are the most important factors for support of the health programmes.*
- *Continuing education - It should aim at updating of existing skills and also for acquisition of new skills and knowledge. Knowledge and skills acquired during basic training may become obsolete and changing patterns of diseases and of the health delivery systems may make new demands on the health workers.*

The point is that attention was drawn to HR issues and suggestions made for health manpower management. So the question arises as to why such recommendations were not taken heed of, why were they not considered, taken forward, acted upon and implemented. In Orissa we see that for more than two years now the government doctors have been demanding implementation of transparent transfer and promotion policy and of the DACP, among other issues ([www.omsa.in](http://www.omsa.in)). These have been met by the state government with repeated assurances, as well as threats of arrest under essential services provisions and of cancellation of their registration. In 2010 a large number of doctors, including the office bearers of their association, were transferred; this was viewed by the doctors as a 'punitive' measure, meant to scuttle their demands ([http://www.telegraphindia.com/1100703/jsp/orissa/story\\_12635987.jsp](http://www.telegraphindia.com/1100703/jsp/orissa/story_12635987.jsp)). The state government was reported to have constituted a ministerial committee in August 2010 to examine the DACP scheme for government doctors. There seem to have been no developments on that front as the demand for implementation of the scheme remained at the time of this study in early 2012.

The question arises - Why is the government not addressing the problems of the doctors and the issues raised by them? As mentioned by a few respondents, "The government was just announcing schemes, but not serious about them; there was no consistency or continuity in the government schemes and rules.....these are knee-jerk responses".

*"Alas! These hospitals are falling upon hard times. The indifference of the government and other agencies in the public sector towards health in general has starved them of funds and equipment. The respect with which administrators and other doctors in these institutions were once treated has given way to the imposition of dictats and*



*encouragement of servility. Ministers, legislators, secretaries in the various departments of government and other bureaucrats revel in making the staff members beg for what should be theirs by right. Playing one against the other and using the weapon of transfer from one city to another, those wielding the political reins of power have played havoc with once respected institutions such as the Sir J. J. Group of Hospitals. Staff members are made to kowtow to their political masters. Loyalty to the institute has been replaced by homage to the powers- that- be. Is it any wonder that these institutions, once internationally renowned, are now in disgrace? Their place is being taken by the private hospitals that have commercial gain as their guiding principle. With a plentiful supply of funds and the ability to provide gold mines for those serving in them, they prove powerful magnets. Fine young doctors who would have otherwise graced the teaching hospitals and done full justice to patient care, teaching and research are now, instead following the pipes played by those in command in these five- star settings.*

*The diversion of the cream of the profession from the task of building and sustaining public institutions of merit to that of accumulating ever- increasing riches is destroying the public health system" (Muralidhar 1993).*

The above lament of a doctor from an urban municipal government hospital in a metropolitan city very clearly brings out the reasons behind doctors not opting to work in public sector institutions. It gives an idea of how factors such as bureaucratization and the neglect of public sector institutions over the years (the push factors), as well as the presence of commercially oriented private hospitals in urban areas (the pull factors) are influencing choices of doctors regarding their site of work.

The neglect of public sector institutions only worsened with the introduction of reforms in the 1990s, when state governments in their attempt to reduce expenses, adopted measures such as cuts in staff and freeze on recruitment, as in case of Gujarat since 1998. These orders adversely affected the normal process of recruitment leading to large vacancies, and also affected services in hospital and health centres. Even recruitment for replacement purposes of retiring staff was not done in many of the states. A case study on human resources for health, conducted in Madhya Pradesh and Gujarat, found that majority of recruitment in these states after 2000 had been on *ad hoc* basis (Government of India 2007). Personnel working on *ad-hoc* basis for long duration are deprived of a number of benefits which are otherwise available on regularization. This is a leading cause of dissatisfaction and de-motivation among such staff; hence attrition of contractual staff is quite high. Yet, the policy of appointing staff on contractual basis continues to be adopted, as a short term solution to the actual requirement. In addition to these recruitment issues, states also stopped creating new health facilities.

The issue here is that policies such as reducing government staff to reduce government expenditure that seem to be outside the realm of health system drastically affect functioning of health services. Can vacancies be filled and shortages of health personnel removed without changing such policies? Further, can the issue of governance and good management be addressed without



confronting the issue of corruption and political patronage, prevalent in almost all the states, to a greater or lesser degree? For instance, there was large-scale corruption in Orissa in the World Bank Health System Development Projects.

### III. Working and Living Conditions for health personnel

We find that in the present discourse on shortage of doctors for government hospitals and for rural institutions, the present dysfunctional status of public sector institutions and the unsatisfactory working conditions are an entirely neglected matter, or at best given a token mention. Lack of basic amenities, poor living conditions, lack of transport, all these have come to be accepted as inevitable features, as a defining characteristic of "rural settings", almost a 'sine qua non' for rural areas. While poor service and living conditions are identified as one of the factors dissuading doctors from going to rural areas, yet measures have not been taken to improve them, although recommendations to this effect have been made by the Bajaj Committee in 1987, as mentioned earlier in this section.

The problem of lack of basic facilities, lack of infrastructure, supporting staff, equipment, in many public hospitals, all these exist in many other states, and are not unique to Orissa. We find that these are critical issues also in other parts of the country, as indicated by the following responses to an e-discussion, on posting and transfer policy for health staff in rural areas and what should be done to ensure adequate staff there (Solution Exchange 2006). We reproduce verbatim some of the responses from health personnel working in different parts of the country, to emphasize the persistence and prevalence of this problem across the country. They corroborate our own findings from Orissa.

"One look at these CHCs and PHCs will tell us why doctors and health workers would refuse to have these as their work environment..... Poor condition of the buildings is compounded by the lack of furniture, electricity, toilets, drinking water etc. One cannot entirely blame the doctors and health workers if they refuse to work out from these places, there are enough doctors and health workers who are committed to their role and do definitely wish to discharge their responsibility, even if it means being away from their homes in the cities and towns, and having to travel to the beyond. What is the infrastructural support available for them?"

"Need to look beyond statistical figures and look at the quality aspects of the numbers - in this case the quality of the infrastructure themselves is important".

"Working outside one's hometown was not the problem so much as the issue of the infrastructure in their place of posting".

"Doctors do not stay in nearby towns for luxury. They do it for safety and fear of life. Forget the NSS/NCC Experience and two day camps".

"If the problem is a simple one, doctor is NOT needed". "If the problem is a bigger one, Doctor ALONE without equipments to monitor is of NO USE". ..... "In the name of being under the shackles of World Bank, government has stopped recruitments and there is a severe shortage of manpower. In one block, there are just 3 health inspectors for a total of 50 vacancies. In any cadre, there is at least 40% vacancy" (from Tamil Nadu).



"The high vacancies in rural areas need a multi-pronged approach and here we must keep in mind that not all factors are concerning the Health Department. If we want a doctor to stay in the rural area at least basic amenities must be provided. They need proper roads, electricity, basic education facilities and safety".

"The problem with existing mindset of bureaucrats, politicians is that they compare the roles of a city doctor posted in Apollo or KEM with that of a doctor in the rural areas. The doctor in a PHC has a role, which is more than medical and that is of an "officer" as well. Things like these are genuine factors; we should not try to answer every question by saying "because doctors don't want to work in rural areas". The excess administrative hassles are important factors, which should also be addressed along with the "Rural" problems. Medical Officers of PHC should be given (Restored - the powers were once assigned) the power to initiate and pass orders over disciplinary action on erring co-workers".

"Many doctors "run away" (sorry for the word) from PHC usually not because of the rural setup, but mainly because of the Administrative Headache; where one is answerable to everyone from Ward Councilor to Minister, District Collector to the press, but one can do nothing about a worker who does not even turn up for work. Those working in cities may be aghast reading this line, but this is the reality. The discipline you see in cities is 100 times more than what is there in the villages. This can be easily proved if you look at the PHCs that have a lot of vacancies. They are not always in the remote places. People try to get out mainly because of the local inter-personal problem and the "rural" concept (though it exists) is secondary".

"Take the case of doctors in Kerala ... there was a time when doctors were paid salary equivalent to district collector and the SP... what's their salary now? What's a doctor's salary now? Not saying that the tasks can be equated... But still doctors deserve a better

Apart from these views on such discussion forum, the importance of improving living and working conditions for attraction and retention in rural areas is brought out by other studies (Lehmann et al 2008). A recent World Health Organization expert group on "increasing access to health workers in remote and rural areas through improved retention" strongly recommends that attention be paid to improving living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools etc.) 'as these factors have a significant influence on a health worker's decision to locate to and remain in rural areas' (WHO 2010 p 30).

The report makes other important observations, namely that 'The absence of direct evidence that improving rural health infrastructure and living conditions contributes to increased retention of health workers in rural areas is mainly because few large scale programmes have been implemented. On the other hand, there is ample supportive evidence. In studies that aim to elicit the factors that influence decisions to work in a remote or rural area, the availability of good living conditions is always mentioned as very important. This includes accommodation, roads, electricity, running water, Internet access, schools for children and employment opportunities for spouses. A study of South African doctors listed



better accommodation as one of the three most important factors that would influence them to remain in a rural area. A study in Bangladesh revealed that remoteness and difficult access to health centres were major reasons for health worker absenteeism, while health personnel working in villages or towns with roads and electricity were far less likely to be absent. Anecdotal data reinforce the results of studies indicating that the lack of appropriate housing, electricity and phone service, and inadequate schools, all act as disincentives for rural service”.

In our study most doctors, belonging to and educated in other districts, were reluctant to be posted in the KBK areas because of their ‘backwardness’; a posting here is looked upon as a ‘punishment’ posting and doctors have to be given incentives to work here. Troubling Questions also arise about this issue of regional backwardness, which invariably is sought to be addressed through such measures as ‘hardship allowance’, ‘difficult area allowance’, and so on, ..... instead of posing and confronting the issue of why certain areas continue to remain ‘backward’ and deprived of basic facilities?

The WHO Report cited above also recommends providing a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive, and thereby increase the recruitment and retention of health workers in remote and rural areas. According to it, ‘Supportive evidence from satisfaction surveys shows that health professionals are disinclined to apply for or accept assignments to practice in facilities that are in a state of disrepair and that do not have basic supplies, such as running water, gloves, elementary basic drugs and rudimentary equipment, because this dysfunctional work environment severely limits their ability to practice what they have been trained to do. In addition, supportive supervision is also a key element that contributes to improved job satisfaction, performance and subsequent retention and practice in rural areas’ (WHO 2010 p 31).

### **Can individual policy decisions work without a larger qualitative change?**

We see that whether it be in the area of medical education & training, or whether it be that of governance, isolated measures such as only incentives, financial and non-financial, are being implemented. It has been adopted almost as a “first-aid” measure, as a knee-jerk response, when confronted with shortages of health workers in rural or remote areas, without enough knowledge about the effectiveness of such interventions or about its sustainability in the long run. Promotions, transfer, better salaries, that are critical HR issues in public sector, and are being repeatedly raised by the doctors themselves, are not being addressed adequately. Poor infrastructure, lack of even minimum working and living conditions, have been ignored –even though these factors have been found to figure prominently in the considerations of doctors while making choices and preferences for work in these areas. In addition, there are issues external to the health system,



arising from overall regional backwardness of certain region, specifically the tribal areas.

What is being done is to somehow get some doctors to join, through some piece-meal measures. By devising such schemes targeted at doctors the government is evading addressing squarely the primary reasons for why doctors are not joining and staying. This amounts to shifting the blame on to doctors for not working even after getting incentives, and conveniently diverts attention away from all the other problems discussed earlier – those of dysfunctional or non-existent infrastructural facilities, poor living and service conditions, of rampant commercialization of medical education and practice, and of larger policy issues favouring reduction of role of the state. It diverts attention away from why some regions remain 'chronically backward' and why compulsory posting is made, why special incentives have to be given to 'lure' doctors to work in such areas? Given these circumstances, it is not surprising that doctors are turning away from public services and ask, 'Why are medical students expected to make greater sacrifices than other professionals?'

We find that there are a host of problems internal and external to the health system that need to be addressed to put in place a functional health system, and that would then get in doctors to work. While the problem is multi-faceted and complex, the strategies being advocated and adopted for redressal are usually not always comprehensive and often limited to addressing a single or limited number of factors in isolation. Despite recent increased rhetoric, human resources remain a sorely neglected and grossly under-financed component of health systems and health system reform programmes. Whereas, as suggested by the Bajaj committee, planning production and management of human resources for health has to be an integral part of and have a functional linkage with the total health system.

Several questions arise; as well as concerns with respect to the intentions of the government. What are the barriers to achieving these satisfactory working conditions for doctors? Why are the comprehensive strategies and systemic approaches ignored and only such piece-meal measures implemented? Is the government at all interested in addressing all these questions, or is it content with this minimalist approach wherein some centrally funded programmes of NRHM for achieving 'national level targets' are implemented through the government facilities, and some skeletal services are provided, in single-doctor PHCs and CHCs, and by the handful of doctors in the district level facilities? Is it that the government and administrators are not aware of these problems? Why is the state government not investing in improving the health infrastructure in the state? What has been the impact of the several measures implemented as 'health sector reforms' for more than a decade? We find that infrastructure is still lacking, especially in the tribal-inhabited areas. What has happened to the loans taken from the World Bank in the name of improvement of infrastructure at the secondary level? Why does the KBK region continue to be labeled 'chronically backward' in spite of crores of rupees shown to be allocated for its uplift and development?



Improving rural infrastructure is part of the overall development of rural and remote areas. It is a measure and strategy that, among other things, will not only help to improve health worker retention; it will also be of benefit to the local population, and to workers from other public sectors such as teachers, as well. One fails to understand why this has not been achieved after so many years of programmes and projects for backward and tribal area development.

The lack of interest of the policy-makers and decision makers in these questions gives credence to the arguments and perceptions – that the government does not want to bring about improvements, but by such inaction and acts of omission is making way for the private sector. One has to consider the influence and impact of the larger political ideologies and compulsions of neo-liberalization and the drive by the states towards promoting private interests in every sector, especially in the social sectors.

### **Conclusion: Implications for policy**

This study indicates that incentives alone on their own are not going to improve availability of doctors for peripheral government health facilities. They have to be part of a larger policy measure to genuinely improve the quality of government health services, which in turn demands political commitment to create a favourable environment, to laying down appropriate policies and make resources available for improvements. The current policy statements of providing universal healthcare services provide an opportunity to move in this direction.

All doctors, both in incentive and non-incentive district, said that if all the problems faced by them are solved – if infrastructure is developed, living and working facilities are improved, transport facilities made available, service conditions are improved, then doctors will join and stay. If situation is improved then doctors may go to the periphery. Several suggestions were made by the respondents to improve recruitment and retention. These could be the first steps towards initiating a discussion on the issues raised, towards involving the doctors themselves in addressing the problems, and acting on the outcomes of such processes within specific time frames. Such as:

- Need to first have a human resource mapping, and an assessment of ground reality. Doctors cannot be forced to work in the present situation.
- A phase-wise approach to improve the system, involving needs assessment, transfer policy, bifurcation of cadre, clear policies regarding DACP and time bound promotion. Undue prolonged bureaucratic delays should be avoided. There should be a separate pay structure for doctors.
- Need overall improvements in infrastructure. There should be proper infrastructure for every institution. The quality of staff quarters has to be



improved with proper electricity, water supply and good road connectivity. There are some areas that become inaccessible in the months of July-September (monsoon) - it becomes difficult to enter these areas even by vehicle.

- Problem of specialist posts – only doctors posted against declared specialist posts are given the specialist allowance; those not in the declared posts are not considered as specialist even if they are qualified as one.
- Administrative and clinical work need to be separated. Separate medical and public health cadres were needed.
- Train paramedical cadre could work in institutions up to block level. The proposed BRMS may help in bringing about improvements.
- Posting AYUSH may be of some help. The state DHS has provision for posting of AYUSH doctors through the PSC; however very few were being employed.
- Extending age of retirement will not help. Employing retired doctors also does not help, as they can only do OPD work, cannot attend to emergencies, MLCs, etc. These are knee-jerk responses.
- The younger doctors felt that there should be an increase in the number of seats for PG, and the reservation given for in-service doctors should be strictly implemented. There should be some relaxation for qualification, as doctors found it difficult to study for the entrance examination given the heavy work load in most facilities.
- If at all incentives are given, then the amount should be increased. Given the variations within even one district, there should be differential/graded amounts accordingly. Some blocks within a district are worse off than others within the same district. Female health workers under state government should also get incentives for difficult areas, as under NRHM<sup>4</sup>.

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<sup>4</sup> Under NRHM the health institutions have been categorized by several criteria: inaccessibility and location of service centres – in terms of distance from nearest urban centre-distance from highway or road, availability of transport and housing facilities – whether government accommodation or rented; characteristics of sub-centres; whether in KBK+ blocks, whether in tribal blocks; in LWE-areas perception of risk regarding law and order; accordingly areas have been graded from V0 to V4, depending on their vulnerability scores. Incentives are given to the field staff and MOs of mobile health units in these areas.

- The Sub-Divisional Hospitals in towns need to be strengthened to take the load off the District Hospitals.
- NRHM needs to be separated from the clinical jobs, and there should be a separate structure for it.
- Consumer protection mechanisms like COPRA and the Doctors' Security Bill need to be enforced properly.

*"If all these things are not sorted out, if the same situation persists, then there will be no doctors for government service. While middle level doctors are there now, entry level doctors are not there. After 5 years there will be doctors only in DH and medical colleges; there will be no-one in periphery; will be doomed. **There has to be political commitment to improve the situation.** Doctors cannot pursue this; we do not have time".*



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## **ANNEXURES**

- Annexure I: Government Notification on incentives for KBK – 2007  
 Annexure II: Government Notification setting up state HRMU - 2009  
 Annexure III: Government Notification on re-naming of Block PHCs - October 2010  
 Annexure IV: Recent Government Notification on incentives – 2012



GOVERNMENT OF ORISSA  
HEALTH & FAMILY WELFARE DEPARTMENT

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No. \_\_\_\_\_/Date: 7.8.2007  
I-Med-IX-M-21/05

**RESOLUTION**

Doctors posted in KBK districts often face various hardships. Therefore in order to encourage them to work in these districts, Government after careful consideration have been pleased to introduce new incentives and enhanced the existing financial incentives to various levels of doctors which include regular Asst. Surgeons and Specialists of all categories (Class-II, Jr. Class-I and Sr. Class-I) and Medical Officers holding administrative posts (Jr. Class-I and Sr. Class-I) working in Koraput, Malkangiri, Nowrangpur, Rayagada, Bolangir, Sonepur, Kalahandi, Nuapada, Boudh, Kandhamal & Gajapati districts as mentioned below:-

- i) Assistant Surgeons & Specialists of all categories (Class-II, Jr. Class-I and Sr. Class-I) and Medical Officers holding the administrative posts (Jr. Class-I and Sr. Class-I) working at the District Headquarter Hospitals/Sub-Divisional Hospitals of Koraput, Malkangiri, Nowrangpur, Rayagada, Bolangir, Sonepur, Kalahandi, Nuapada, Boudh, Kandhamal & Gajapati districts are granted an additional incentives of Rs.4,000/- (Rupees four thousand) only per month.
- ii) Assistant Surgeons & Specialists of all categories (Class-II, Jr. Class-I and Sr. Class-I) and Medical Officers holding the administrative posts (Jr. Class-I and Sr. Class-I) working in the Peripheral hospitals/dispensaries etc. (other than the District Headquarter Hospitals/Sub-Divisional Hospitals) in the above mentioned 11 districts are granted an additional financial incentive of Rs.8,000/- (Rupees eight thousand) only per month.
- iii) The Medical Officers of Jr. Class-I and Sr. Class-I ranks holding the administrative posts can draw the aforementioned incentives on the condition that apart from their administrative work they should also undertake both treatment & clinical work.
- iv) The Medical Officers in charge of Community Health Centres/Upgraded Primary Health Centres/Area Hospitals/Primary Health Centres shall furnish a certificate every month to their concerned Chief District Medical Officers in respect of the doctors working under their administrative control to the effect that the concerned doctors have stayed and worked throughout the month in their respective places of posting before drawal of their monthly salary.
- v) The Chief District Medical Officers/Sub-Divisional Medical Officers shall also furnish such certificates every month in respect of the doctors (Asst. Surgeons

& Specialists, Class-II, Jr. Class-I & Sr. Class-I rank and Medical Officers holding administrative posts) working under their administrative control in the District Headquarter Hospitals/Sub-Divisional Hospitals before drawal of their monthly salary. In case it is found that a doctor has been paid even when he has not stayed in the place of posting or he/she has not performed the duty as stipulated in this order, such amount will be recovered from the certifying officer.

- vi) This incentive will not be admissible on account of absence exceeding 4 days (including public holidays) for attending training/workshop/seminar inside & outside the country and during joining time on account of transfer.
- vii) The doctors availing leave of any kind except Casual Leave will not be eligible to draw this incentive.
- viii) The Drawing & Disbursing Officers will draw the incentive as admissible on the basis of such certificates alongwith the monthly salary.
- (ix) Such financial incentives will be applicable for a period of one year only from 1.8.2007 to 31.7.2008 subject to review by the Government.
- x) There shall be test checks by the concerned Collectors of the districts regarding regular attendance of the doctors.
- xi) The Chief District Medical Officer concerned will incorporate the information regarding presence and delivery of service of Medical Officers holding the administrative posts in their respective headquarters in his/her fortnightly confidential report to Collector. The Collector will also reflect the same in his/her FCR.
- xii) The above incentive will not be admissible unless the Medical Officer is deployed against an substantive post either in the District Headquarters/Sub-Divisional Headquarters or elsewhere within the specified districts.

This has been concurred in by Finance Department in their UOR No. 2544 /PSF dt.19.7.2007 and UOR No.2613/PSF dt.24.7.2007.

By Order of the Governor

Sd/-

Special Secy. to Government.



GOVERNMENT OF ORISSA  
HEALTH & FAMILY WELFARE DEPARTMENT

No. 15691/H. dated 16/09/09  
Sch-KBK-6/09

OFFICE ORDER

Sub: Establishment of a State Human Resource Management Unit (SHRMU) in Combined Health Directorate, Health & Family Welfare Department, Govt. of Orissa.

The Department of Health & F.W. is a large organization with immense requirement of skills and competencies. Human resource planning management and estimating human resource requirement based on needs is a comprehensive specialized process requiring considerable expertise.

In order to streamline human resource management in the Health Sector, it has been decided by Govt. to establish a State Human Resource Management Unit (SHRMU) in the Combined Health Directorate. The said Unit will be an institutional mechanism enabling Policy Planning and Research on human resources for Health & F.W. Deptt, Govt. of Orissa.

It will have the following institutions under its umbrella:-  
Directorate of Health Services, Orissa, Directorate of Family Welfare, Directorate of Medical Education & Training, Directorate of State Institute of Health & Family Welfare, Directorate of Drugs Control, Orissa, Directorate of Indian Medicine & Homeopathy, Orissa State AIDS Control Society, National Rural Health Mission, Norway India Partnership Initiative & Technical Management & Support Team (DFID).

The objective of the said SHRMU will be formulation of human resource policy, planning, management, monitoring and evaluation, ensuring adequate supply of required skills to meet present and future needs of human resources in the health sector.

**GOVERNMENT OF ORISSA**  
**HEALTH & FAMILY WELFARE DEPARTMENT**  
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No. 78589 /H. dated 8-10-10  
Sch-II Med-18/09

**NOTIFICATION**


***Sub: Re-naming of CHC, Block PHC and Area Hospital as Community Health Centre (CHC).***

With a view to rationalizing the health institutions in the State, Govt. has been pleased to re-name **116 Block PHCs** and **35 Area Hospitals** as **CHCs** as at Annexure- 'A', without creation of additional posts. Existing posts, however, have been rationalized as per Resolution No- 4994/H. dated 26<sup>th</sup> May, 2004 Health & FW Deptt.

2. In the event of re-naming of Block PHCs and Area Hospitals as CHC, the existing 226 CHCs will continue as CHC as before and thus there will be a total of 377 CHCs in the State. The nomenclature : 'Block PHC', 'UGPHC' or 'Area Hospital' will not be used henceforth.
3. Doctors and Specialists will be posted in the CHCs so re-named, subject to availability of doctors.

Ordered that this notification be published in an extraordinary issue of Orissa Gazette.

By Order of Governor

  
(Anur Garg)  
Commissioner-cum-Secretary



GOVERNMENT OF ODISHA  
HEALTH & FAMILY WELFARE DEPARTMENT

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RESOLUTION

No. 1489 / H, dated 20.01.12  
I Med-MISC-09/11

1. It has been noticed that there is chronic absenteeism of doctors in KBK and KBK+ districts like Koraput, Malkangiri, Nawarangpur, Rayagada, Bolangir, Subarnapur, Kalahandi, Nuapada, Boudh, Kandhamal and Gajapati. Vacancies of Medical Officers are not filled up in these districts which creates problems in providing health care to the people in these areas.
2. With a view to ensuring Medical Officers to join in those districts, Government have decided to grant financial incentives to the regular Medical Officers of different categories working in those districts. Over the period, resolutions/circulars/instructions have been issued along with relaxation or addition of some provisions. In super session of those circulars/instructions issued in this regard earlier, vide Resolution No. 20214, dtd. 07.08.2007, No. 22930, dtd. 13.10.2008, No. 1105, dtd. 21.01.2010, No. 10821, dtd. 04.05.2010 & No. 7531 dtd. 28.03.2011, Government after careful consideration have been pleased to formulate a comprehensive resolution for providing incentive to Medical Officers working in K.B.K. and K.B.K.+ districts as mentioned below.
3. **Financial incentives to be given in the districts.**  
Koraput, Malkangiri, Nawarangpur, Rayagada, Bolangir, Subarnapur, Kalahandi, Nuapada, Boudh, Kandhamal and Gajapati.
4. **Medical Officers entitled for the incentives.**  
All categories of Medical Officers holding substantive and administrative posts of J.D. Level-I, J.D. Level-II, Sr. Class-I and Jr. Class-I and engaged in treatment and clinical work in the District Headquarters Hospitals, Sub Divisional Headquarters Hospitals, and peripheral Hospitals / Dispensaries in the districts as mentioned at Para-1 above.
5. **Amount of incentives.**
  - (a) Incentive of Rs.4000/- per month over and above the salary for working at DHHs and SDHs in above districts.
  - (b) Incentive of Rs.8000/- per month over and above the salary for working at peripheral/dispensaries in above districts.
6. **Period of incentives available.**  
The incentive will be made available for a period of one year i.e. from 01.08.2011 to 31.07.2012 subject to review by Government and further concurrence from

Finance Department every year and communication made to the CDMOs by Administrative Department.

**7. Eligibility for getting incentives.**

- (a) Medical Officers holding the administrative posts are eligible to get the incentives on the condition that apart from their administrative work, they should also undertake both treatment and clinical work. A certificate to this effect should be given by CDMO of the district. **In case of CDMO, the certificate is to be issued by the Collector of the district.**
- (b) M.O. I/C of CHC, other health institutions shall furnish a certificate every month to their concerned CDMO in respect of the doctors working under their administrative control to the effect that the concerned doctors have stayed and worked throughout the month at their respective places of posting before drawal of monthly salary.
- (c) The CDMO/SDMO shall furnish such certificates every month in respect of Medical Officers working under their administrative control at DHH/SDH before drawal of their monthly salary. In case, it is found that a doctor has been paid even when he/she has not stayed at the place of posting or he/she has not performed the duty as stipulated in the posting order, such amount will be recovered from the salary of countersigning officer.
- (d) The incentive will be admissible on account of attending training/workshop organized by government/NRHM/ sponsored by Govt of India only inside the State and country. But, it will not be admissible for training/workshop organized by private organization/institution.
- (e) The Medical Officers availing leave of any kind except casual leave are not eligible to get the incentive.
- (f) The incentive is not admissible on account of long absence or unauthorized absence and during transit or joining time period on account of transfer. In other words, it is admissible for the M.Os actually working in health institutions and staying at the place of postings in the specified districts. In no case, it will be given when one M.O. is attending duties by commuting from other places to the place of posting.



(g) The incentive will not be admissible unless the M.O. is deployed against a substantive post either in the District Headquarters or elsewhere within the specified districts.

**8. Responsibility of Drawing and Disbursing Officer.**

The DDO will draw the incentives as admissible on the basis of certificates as indicated above along with the monthly salary.

**9. Checking by the Collector of the district.**

There shall be test check by the concerned Collector of the district with regard to regular attendance/absence of Medical Officers from headquarters or place of posting in various health institutions in the district. On receipt of such reports from the Collector, the CDMO will take steps for drawal/disallowing of incentives as and when required.

**10. Responsibility of CDMO**

In case of any lapses noticed in contravention to the above principles, the CDMO will be held responsible for such lapses and disciplinary proceeding under rules shall be taken against him.

This resolution will come into force with immediate effect.

This has been concurred in by Finance Department in their UOR No. 275 SS-III,

Dtd. 18.10.2011

ORDER :-Ordered that the resolution be published in the next issue of the Odisha Gazette for general information.

By order of Governor

Commissioner-cum-Secretary to Govt.

Memo No 1490 /H. dated 20.01.12

Copy forwarded to Director, Printing, Stationary and Publication, Orissa, Cuttack for information and necessary action.

He is requested to furnish the Resolution in the next issue of the Orissa Gazette and supply 50 (fifty) copies of the printed Resolution to this Department.

Joint Secretary to Government



## PHOTOGRAPHS



Living Accommodation for doctors at a CHC, Koraput



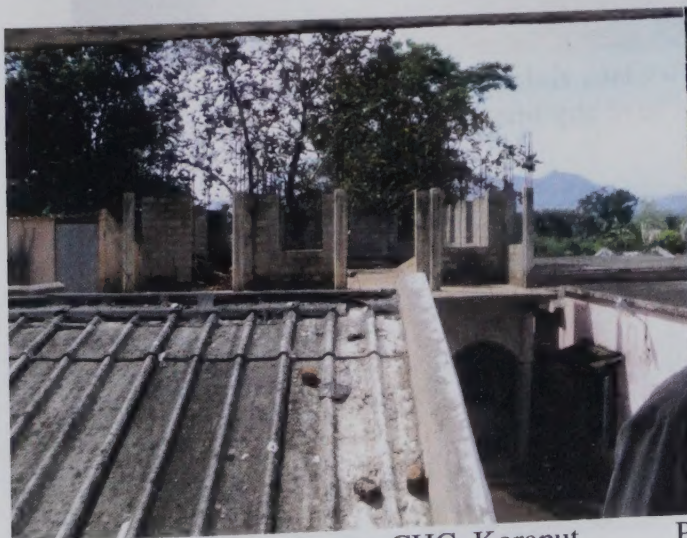
Living Accommodation for doctors at a CHC, Kalahandi



CHC premises Kalahandi.  
Staff quarters in background (pink building)



Construction work at a CHC, Koraput



Incomplete construction at a CHC, Koraput



PHC premises, Koraput. Many CHCs and PHCs still have asbestos roofs.





Building for doctor to sit in, CHC, Kalahandi



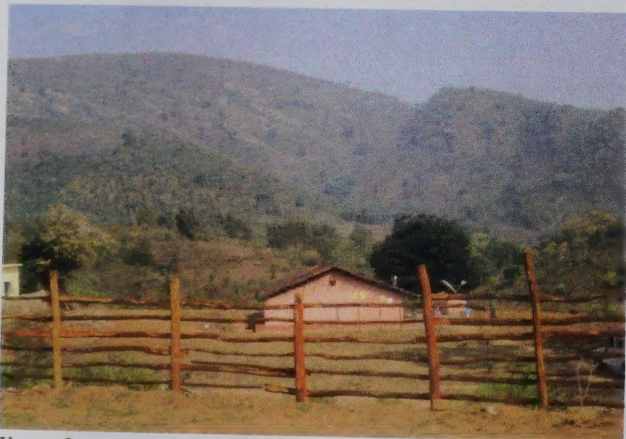
Inside a PHC (New), Mayurbhanj



Quarters for staff at a PHC (N) Kalahandi



Inside a PHC (New), Mayurbhanj



View from a PHC of the hilly terrain, Kalahandi



Ward in a CHC, Kalahandi. Beds, where available, did not have any linen



Parts of the all three districts are hilly and densely forested







## **About PHRN**

**Public Health Resource Network (PHRN) is a voluntary network of many hundred concerned public health practitioners who are willing to intervene towards 'Health for All' by creating capacities and engaging with the public health system. It is a civil society initiative for supporting and strengthening public health systems in India. Public Health Resource Society is the core group that has initiated PHRN.**

## **PUBLIC HEALTH RESOURCE NETWORK**



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